DOCTOR OF HEALTH (DHEALTH)

Development of Health Policymaking Governance Guidance Tool (HP-GGT)

Hamra, Rasha

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University of Bath

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Rasha Saadi Hamra Ambriss

A Thesis Submitted for the Degree of Professional Doctorate in Health

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Dedications

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List of Abbreviations

COI	Conflict of Interest
EMRO	Easter Mediterranean Region
EBQ	Evidenced-Based Questions
GG	Good Governance
HP	GGT Health Policymaking Governance Guidance Tool
HSG	Health System Governance
KIs	Key Informants
LMICs	Low to Middle Income Countries
MHS	Mental Health Strategy
MoH	Ministry of Health
MOU	Memorandum of Understandings
NCD	Non-Communicable Diseases
NGO	Non-governmental Organization
PBQ	Perception Based Questions
SMART	Specific, Measurable, Achievable, Realistic and Timely
SWOT	Strengths, Weaknesses, Opportunities, Threats
UNDP	United Nation Development Program
WB	World Bank
WHO	World Health Organization

Abstract

Assessing and understanding governance at all levels of the health system is crucial to improve the way in which the system is steered and managed and thus might positively affect (among other things) its performance, and ultimately, health outcomes. This association needs to be further explored by more research in order to confirm the type of relationship between governance and health outcomes, but first we need to define it and assess it in a pragmatic way. Previously, several assessments tools for health governance were proposed; but, due to a range of reasons, they are not being widely employed. Thus, there is a need for a new assessment tool to address some of the limitations of the existing ones (one that is specific to the health sector, practical, and capable of assessing change and progress over time) and help fill some of the gaps in knowledge (such as supplementing conceptual depth to the governance principles covered). Additionally, policymakers require a diagnostic tool to identify deficiencies in governance that need to be addressed.

This research involved the development of a valid generic tool, suitable for assessing the principles and practices of governance in health policymaking, as well as providing a structured opportunity to policymakers to critically reflect on good practices. The assessment/guidance instrument covers five fundamental principles of good governance (GG) as yet insufficiently explored within the literature on health governance or systematically operationalised. These are participation, transparency, accountability, use of information, and responsiveness. The tool was developed over five steps (three stages). Stage one focused on the conceptualisation of the five selected principles based on a review of the available literature, with the aim to compile concepts/characteristics of GG under each of these principles and operationalise them into a list of questions, which comprised the initial tool. In stage two, the tool was refined by conducting three rounds of online Delphi consultations with 25 experts from 16 countries. These consultations helped attain consensus on the most important characteristics of the governance principles and explored new attributes that were not identified through the literature search. Moreover, the tool was reviewed by seven high-level policymakers from seven different countries, mainly to consider its practical application in the health context. Stage three pertained to pilot testing the refined tool with regard to a new national policy on mental health in Lebanon in order to identify GG practices as well as possible gaps in its formulation. The results of the assessment were presented with recommendations to the relevant policymakers.

In conclusion, the end product of this research is a Health Policymaking Governance Guidance Tool (HP-GGT) that can be readily used by policymakers at the Ministry of Health level and/or by health authorities. It offers guidance concerning a list of "good practices" for reflexivity that could lead to enhancements in health policy governance.

Chapter One

Introduction and Research Question

This chapter introduces the general implication of governance, including commonly employed definitions of health system governance (HSG) that are used, its importance, levels of health system in which governance has a role, the salience of assessing HSG, the principles of GG, as well as the available assessment tools, their limitations, and gaps. Subsequently, the need for and importance of bridging some of the gaps in previous and current work concerning the operationalisation and implementation of HSG assessment is considered. Drawing on the existing literature, the necessity for a new governance tool is proposed and the expectations from this new tool in terms of what it can and cannot achieve are addressed. The chapter concludes with a proposal of the research question this research will address.

1.1 Introduction

1.1.1 What is Governance?

Governance is considered a relatively new field in the development agenda, although the underlying concepts and principles of governance date back to early human civilisation (Mailk, 2002), with references to these present in many religions, including Christianity and Islam (Saltman and Davis, 2000). Governance is recognised by many policymakers and researchers as a fundamental ingredient for development across various policy fields (Kaufmann and Kraay, 2008). Accordingly, the improvement of “governance” and promotion of "good governance" have become subjects of interest for policymakers and scholars alike (Fryatt, Bennett and Soucat, 2017).

This concept was developed and expanded on in the fields of political science, social sciences, public policy, and economics (Kaufmann and Kraay, 2008). This implies that the concept emerged from different disciplines (Pyone, Smoth and Broek, 2017), which rendered reaching a consensus regarding its conceptualisation a difficult task (Barbaza and Tello, 2014). Governance has several implications (Laurance et al., 2000; Dodgson, Lee and Drager, 2002; Lewis and Pettersson, 2009; Veillard et al., 2011; Savedoff, 2011;

Emerson, Nabatchi and Balogh, 2011) that has resulted in the problematisation of the concept, leaving questions as to whether the different conceptualisations and definitions have enough in common to enable their use in research and policymaking. According to Bovaird and Loffler (2003), the "vagueness" associated with governance has led to the concept's "popularity" and resulted in the drive to assess it.

Governance is a generic term that has been used across all sectors (Leadership, Management and Governance Project (LMG) 2012). and entails both managerial as well as political aspects (United Nations Development Program (UNDP), 1997). Despite some key conceptualisations of governance as an issue of organisation management and decision-making in the private corporate sector, these are now widely applied in the public sector as well (Ruhanen, Scott, Ritchie, and Tkacznaki, 2010). Corporate governance is defined as "a set of relationships between a company's management, its board, its shareholders and other stakeholders" (OECD, 2004). It provides the structure through which a company's objectives are set, and the means of attaining those objectives and monitoring performance are determined (OECD, 2004). In other words, governance pertains to the political and administrative activities of creating, organising, and delivering a policy/product (UNDP, 1997). According to UNDP (1997), governance in the public sector concerns the "exercise of political, economic and administrative authority in management of a country's affairs at all levels". In turn, GG, in general, is defined as the "exercise of power through institutions to steer society for public good" (UNDP, 1997). It has been claimed that this is likely to result in processes and outputs that are inclusive, responsive, and fair and will also increase public trust in the social system (Huss, Green, Sudayshan, Karpagam, Ramani, Thomas, and Gerein, 2010). Hence, governance is commonly used to "refer to all patterns of rule to coordinate the relationship between different actors and organizations" (Bevir, 2008). This refers to the normative form of governance, the form this research will focus on in the context of the health sector.

Regarding the health sector, the World Health Organization (WHO) first suggested the term stewardship in health in its World Health Report in 2000, where it defined the government's role towards its citizens in the health sector as comprising a special type of governance (Saltman and Davis, 2000). The World Health Report (2000) defined stewardship as "careful and responsible management of the well-being of the population" (WHO, 2000). Subsequently, the term stewardship was replaced by governance to facilitate understanding and imply the regulation, management, and organisation of the system rather than merely focusing on the ethical and moral values that should be practised in the

management of a health system (WHO, 2007). The WHO offered another definition for governance in 2007, "ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, provision of appropriate regulations and incentives, attention to system-design, and accountability" (WHO, 2007). USAID defined health governance as the "process of competently directing health system resources, performance and stakeholder participation toward the goal of saving lives and doing so in ways that are open, transparent, accountable, equitable and responsive to the needs of the people" (USAID, 2008). Since governance is considered a function of the health system (WHO, 2010), it is required to ensure the achievement of health system goals through fair and ethical management (to reflect ethical values required for public health) of the health sector through national health ministries or governments (Veillard, Brown, Baris, Permanand, and Klazinga, 2011).

When the general definitions of governance and those of health governance are considered, they can be perceived as being broad and abstract (UNDP, 197; WHO, 2007). While it can be concluded that the various definitions regarding the health sector (as in other fields) share a certain degree of similarity in terms of the government's role of steering the system towards what is beneficial for its people, there is no agreement as to a common worldwide definition that should be followed (Barbaza and Tello, 2014). This could be explained by the fact that governance is a relatively new concept as well as a highly political one (Lopez, Wyss and Savigny, 2011). In addition, different perspectives concerning the meaning of governance are not only caused due to issues at the conceptual level but also due to differences in the language used to define the term (WHO, 2007; Veillard et al., 2011).

1.1.2 Different Levels at Which Governance Has a Role Within the Health Sector

Governance is involved horizontally in several fields within the health sector and at all levels vertically (WHO, 2010). Therefore, for instance, reference is made to "Global Health Governance": the international platforms and processes for coordination and collaboration between countries and international organisations to protect their populations' health against public health threats (Dodgson, Lee, and Drager, 2002).

In contrast, at the national level, within a country, the governance of health system plays a role in the way in which structures, actors, and processes shape the overall political direction, level of financing, type of healthcare system organisation, as well as financing

and service delivery of the health system (Siddiqi, Masud, Nishat, Peters, Sabri, Bile and Jama, 2009). These processes of governance within the health sector regarding spending money, determination of general health goals, and provision of healthcare are usually influenced by the parliaments and the political parties, which consult with the respective ministries of health (MoHs) (Savedoff, 2011) and are hence dependent on the country's governance style (Siddiqi et al., 2009).

Ministries of health continue to be the principal governing bodies of health system (Veillard et al., 2011), holding a mandate for health policymaking, operational practices, organisation, financing, and service delivery, which also includes oversights and regulations (Siddiqqi et al., 2009). At this level, the focus of HSG is mainly on the process of policymaking and ensuring that evidence-based policies and procedures are formulated and implemented in a transparent and accountable manner, involving all stakeholders, being responsive and inclusive to the population's needs, thereby reflecting normative principles that guide GG (WHO, 2009). This implies that it is the MoHs' responsibility to ensure that the characteristics of GG, as defined by international organisations, such as transparency, accountability, participation, among others, are established and implemented at the level of policymaking. Focusing on the HSG at the MoH level does not exclude the importance of other factors, such as economic development, public expenditure, inequality, and others, that might affect policymaking in the health sector.

HSG exists at the service delivery level, with the aim to improve practices and services provided, including clinical governance, among other things, that focus on the quality and standard of care of health services offered (Savedoff, 2011). In investigating health governance, it is important to specify the level of focus, as different issues emerge as important depending on the targeted level of governance.

1.1.3 Importance of Health System Governance

Governance is considered one of the core components of health systems (WHO, 2010). According to the WHO, "a health system is sum total of all organizations, institutions and resources whose primary purpose is to improve health", and there are six building blocks for any health system, namely, service delivery, health workforce, information regarding medical products, vaccines and technologies, financing, and leadership/governance (WHO, 2010). The governance's role is to provide the required infrastructure for overall policy and regulation of all other building blocks (WHO, 2010).

"Improving" HSG was perceived by UNDP (1997) and the WHO (2009) as a major factor for the achievement of health millennium goals, social developmental goals (SDGs) (Siddiqi et al., 2009), as well as universal health coverage (Fryatt et al., 2017). Although there is no conclusive evidence that indicates a causal link between GG and enhanced performance of the health system and health outcomes, the existing literature suggests a positive association. In theory, the enhancement of performance and health outcomes is related to the improvement of the health system's governance as this can exert a positive influence on all other health system functions and building blocks (Siddiqi et al., 2009). The literature suggests a positive correlation (to be further confirmed) between GG and the health system's performance improvement, which might lead in turn to improved outcomes (Lewis and Pettersson, 2009). Hence, governance can be considered as one of the indicators (among others) for any health system's performance (Alliance for Health Policy and Systems Research (HPSR), 2008). This, however, does not consider the influence of the other factors (within and beyond the health sector) that influence these system's performance and health outcomes, nor confirms the type of relationship between HSG and system's performance and health outcomes.

Ciccone, Vian, Maurer and Bradley (2014) conducted a review of literature in low- and middle-income countries (LMICs) to ascertain whether there is a link between health governance and health outcomes in these countries. They identified 30 peer-reviewed studies, and 18 of those demonstrated a positive effect in one way or another (Ciccone et al., 2014). According to Ciccone (2014), the effect of governance on health outcomes was found to be either a direct positive effect, an indirect positive effect (modified by contextual factors), or a moderating positive effect. The other 12 studies presented mixed findings concerning the association, showing no association or inconclusive results (Ciccone et al., 2014). The authors concluded that further research is required to understand the relationship between governance and health outcomes; however, meanwhile, policymakers are encouraged to apply GG in their practice: "building upon what we already know about the relationship between governance and health can catalyse new understanding and innovation for a better functioning health system" (Ciccone et al., 2014, p.94). Ciccone et al. (2014) highlighted four key governance mechanisms that affect health outcomes: responsiveness to people's needs, empowering diverse stakeholders' participation in the health sector, enhancement of community engagement, and enabling citizens to hold providers/policymakers accountable (Ciccone et al., 2014). Health outcomes that are impacted by governance mechanisms included infants' nutrition status, under-five mortality rates, service utilisation rates, immunisation rates, introduction of new

vaccines, life expectancy at birth, maternal mortality rates, as well as awareness about contraceptives and their use, according to these authors (Ciccone et al., 2014).

Conversely, it has been reported that poor governance in the health sector might contribute to poor performance, among other problems, and might lead to poor health outcomes in LMICs (LMG, 2012), this is also to be confirmed in future research. For instance, lack of standards, information, and accountability can cause any health system to perform poorly (Lewis and Pettersson, 2009). Siddiqqi et al. (2009) also drew attention to the fact that poor governance pertains to poor accountability and transparency, weak responsiveness, limited engagement of various stakeholders, and lack of data and evidence. This is relevant especially in contexts with limited resources, in which effective, fair, and transparent resource utilisation and distribution can significantly affect the quality and access of services provided, which, in turn, can affect health outcomes (Siddiqi et al., 2009).

The application of GG may lead to the strengthening of the health system (Pyon et al., 2017) and can consequently improve health outcomes in those countries (Ciccone et al., 2014). The influence of HSG on health outcomes is indirect as the process involves several intermediary steps involved. Improving one step might have a role in improving the outcomes but this cannot be guaranteed. For example, if resource allocation and health expenditure is performed in a more accountable and transparent manner, this might result in more effective public expenditure on lowering child mortality (Lazarova, 2006) and/or increasing life expectancy (Makuta and O'Hare, 2015), given that other factors such as the level of bureaucracy and corruption are also enhanced (Haan and Komp, 2008). In addition, international organisations have reported that weaknesses in HSG can threaten the effective utilisation of external funds (USAID, 2008) through wastage and leakage (Siddiqi et al., 2009). Hence, these organisations impose strict requirements on governments to improve HSG as a means to facilitate the management of limited resources and deliver transparent funding, thereby demonstrating accountability towards donor organisations (Alliance HPSR, 2008; Lopez et al., 2011). It is believed that LMICs are the countries that will gain the maximum benefits from enhanced quality of governance as problems at all levels of governance have been reported to affect the level of development (Ruhanen et al., 2010). In general, poor governance was reported as one of the reasons behind governmental inefficiency in LMICs (Andrews, 2008), with inefficiency in health systems, in particular, being attributed to the predominance of a hierarchical system in the management of this sector (Lewis and Pettersson, 2009; Siddiqi and Jabbour, 2012).

It has been reported that the number of publications on health governance in LMICs is limited (Alliance HPSR, 2008) and that assessment efforts so far have been inadequate

(Siddiqqi and Jabbour, 2012), which reflect on poor practices of GG in real settings and thus require further attention.

However, health governance has become a high priority in LMICs due to the emergent demand to enhance accountability and regulation within this sector in order to promote transparency of MoHs as well as engage various stakeholders in the decision-making process (USAID, 2008; Siddiqi and Jabbour, 2012). Accordingly, policymakers, donors, and researchers need to assess and understand the way in which governance operates in these countries at all levels of the health sector (Alliance HPSR, 2008). These stakeholders may have different interests, such as a desire to improve HSG as one of the means to contribute to the improvement of performance and thus the possibility to enhanced outcomes (Lopez et al., 2011), a wish to monitor aid effectiveness as a demand of donors (Lopez et al., 2011; Siddiq et al., 2009), or simply, to expand the body of knowledge regarding governance (Pyon et al., 2017). Regardless of the aim, it is evident that providing a better understanding of the way in which different aspects of governance are operationalised in the context of LMICs presents a worthwhile endeavour.

HSG represents a complex phenomenon (Pyone et al., 2017), being one of the least understood aspects compared to other foundational blocks of the health system (Siddiqi et al., 2009), despite the claims regarding its importance (Ciccicone et al., 2014; Fryatt et al., 2017; Barbaza and Tello, 2014). Scholarship in this field is under developed and the reason for its delayed development could be the fact that governance in the health system forms a complex, sensitive, and consequently, challenging topic to research (Alliance HPSR, 2008).

The reason behind HSG's complexity is the diversity of the stakeholders involved, who have different agendas, interests, beliefs, power, and authority, in addition to external factors' influence on these stakeholders (USAID, 2008). Health governance is also considered a sensitive subject as it has a political dimension that exceeds the health sector (Kaufman and Kraay, 2008). Governance is generally associated with battling corruption, though it entails considerably more than that (WHO, 2009). In addition, health governance is also under researched due to limited funding due to lack of interest to fund governance research, and as mentioned earlier, poor conceptual understanding (Alliance HPSR, 2008).

In a recent article by Fryatt et al. (2017), the authors addressed the question: “Health sector governance: Should we be investing more?”. They presented the argument that despite ongoing issues with regard to the implication of governance and its influence on health being a debatable issue owing to conflicting evidence, the important thing is improving HSG; however, the interventions need to be "realistic" (Fryatt et al., 2017).

1.1.4 Importance of Assessing Health System Governance

In order to improve something, it first needs to be assessed for deficiencies in practice as well as to lacunae the knowledge concerning ways to enhance it (Siddiqi et al., 2009). The importance of assessing HSG is rooted in the necessity to detect weaknesses in the practice of GG. This, in turn, can sensitise policymakers and researchers concerning the need to devise possible approaches and interventions to effect this enhancement (Lopez et al,, 2011; Baez-Camargo and Jacobs, 2011). Additionally, this pursuit in one country can also lead to the documentation of such success, which can then be utilised by other countries as a model of GG (Pyone et al., 2017).

Research efforts for understanding/assessing governance issues in various fields have concentrated on developing the theoretical understanding of the consequences of governance on growth and development at all levels, in all sectors (Al-Marhubi, 2004). Extensive work has been undertaken in high income countries to develop indicators for governance, in general, which have been mainly used by donors and the private sector to decide on the level of economic development and public policy governance for a given country in order to predict investment potential (Mailk, 2002). In addition, international donors put a pre-requisite to giving funding that is documented GG practices at the national level in general and in specific the sector to receive the funding (Bovarid, 2005). However, still no consensus on a universal measurement exists (Smith, Anell, Busse, Grivelli, Healy, Lindahl, Westert and Kere, 2012).

Governance cannot be defined or assessed without defining GG, which is defined, as "institutional barriers to corruption and the requirements for a functioning system" (Bevir, 2009,p.26) being in place. GG in the context of health refers to the "formulation and implementation of appropriate policies and procedures that ensure effective, efficient and ethical management of all aspects of health systems, in a manner that is transparent, accountable, follows rule of law and minimizes corruption" (WHO, 2009, p.3). MoHs/health authorities and other relevant bodies could utilise this definition as a general

benchmark to understand the extent to which their policies reflect the standards for GG (Kaufmann and Kraay, 1999).

The assessment of governance, in general, should facilitate policymakers' understanding of the complex and multidimensional concept in the absence of a consolidated definition.

So, how can policymakers assess HSG, a "conceptually rich" notion that has no unified definition or standardised criteria against which it can be measured?

Recognising the various unclear and abstract definitions of governance, most international organisations have adopted a strongly normative approach towards understanding this phenomenon, suggesting lists of principles constituting GG (UNDP, 1997; Kaufman and Kraay, 1998; WHO, 2000; USAID, 2009; Lopez et al., 2009). However, agreeing on core principles of GG has resulted in the application of numerous lists of principles by different organisations. Ruhanen et al. (2010) conducted a meta-analysis and found 40 different principles across different fields in the literature; even within a specific field, such as the health sector, a variety of lists of principles exist. Table 1 below summarises the findings regarding the principles of governance as understood by various organisations and institutions dealing with the health sector.

Table 1: Principles of Governance According to Various Institutions that Deal with the Health Sector

Organization	Principles of Governance
UNDP, 1997	• Participation • Rule of law • Transparency • Responsiveness • Consensus orientation • Equity • Effectiveness and efficiency • Accountability • Strategic vision
World Bank, 1999	• Voice and accountability • Political stability and absence of violence • Government effectiveness • Regulatory quality • Rule of law • Control of corruption
WHO, Stewardship Domains, 2001	• Generation of intelligence • Formulating strategic policy direction • Ensuring tools for implementation; power, sanctions, and incentives • Building coalition/partnership • Ensuring a fit between policy objectives and organizational structure and culture • Ensuring accountability
USAID, 2008	• Responsiveness • Leadership • Legitimate exercise of voice • Institutional checks and balances • Accountability • Transparency • Evidence-based policymaking • Efficient and effective service provision
WHO ,Siddiqi Framework, 2009	• Participation and consensus orientation • Rule of law • Transparency • Responsiveness • Equity • Effectiveness and efficiency • Accountability • Strategic vision • Ethics • Information and intelligence
Lopez, Wyss and Savigny, 2011	• Addressing corruption • Being transparent • Being accountable • Participation and consensus orientation • Strategic vision and policy design

The most common principles/dimensions across different organisations have been highlighted in red in the above table, while variations can also be observed. These variations demonstrate the necessity for a more systematic approach to defining (not merely listing) the most important principles of governance for the health sector. Equally

important is the assessment of their relevance for a particular level of governance within the health system, as discussed earlier. The WHO has attempted to define GG in the health sector in terms of its core principles through Siddiqi et al.'s (2009) work, in which, ten principles were proposed for HSG based on the UNDP principles (which are widely accepted by most stakeholders, although not universally [USAID, 2008]), allowing slight adjustment to enable them to be more relevant to health systems. This implies that Siddiqi et al. (2009) merged participation with consensus orientation, while also adding the elements of intelligence, information, and ethics. The decision to include these ten principles to define GG in the health sector was made after an extensive consultation led by the WHO Eastern Mediterranean Regional office (EMRO), and these were acknowledged by others as well (Kirigia and Kirigia, 2011; Lopez et al., 2011).

Therefore, after the key principles of GG in the health sector had been defined, the following step was to conceptualise the selected principles based on the literature and determine ways to operationalise them in order to assess HSG in practical terms.

1.1.5 Available Assessment Tools and Gaps When Assessing HSG

Governance partly comprises a "qualitative phenomenon" (Mailk, 2002) as the factors that affect its quality are context-specific, depending on the political, social, and economic context, level of corruption, rule of law, in addition to several other factors that are considered country-specific (Kaufmann and Kraay, 2008; Siddiqi et al., 2009). Despite the fact that this major work, as mentioned before, has been undertaken by international organisations, such as the World Bank (WB), to develop indicators on governance as a way to track progress and change over time, it is not possible to accomplish this with qualitative indicators (Kaufmann and Kraay, 2008). These indicators range from process to performance, subjective to objective, rule-based to outcome-based, single to aggregated, among other indicators (Savedoff, 2011). All of these are widely applied but with some valid critique (Apaza, 2009).

Most of these indicators are employed by international organisations and others to serve their agenda of improving governance based on the assumption that boosting economic development, social development, and/or health outcomes is the most important aspect (UNDP, 1997; Kaufman and Kraay, 2008). This is the reason behind the emergence of the need for indicators to assess different aspects of governance (Baez-Camargo and Jacobs, 2011), despite the political nature of the issues related to it. The indicators developed to

assess governance in various fields are broad as the definition of the term (Mailk, 2002). These broad indicators are based on the abstract concept of governance, resulting in their limited application (Lopez et al., 2011; Pyone et al, 2017). Consequently, there is a need for further in-depth assessment of governance based on "identified" key principles in order to promote a common understanding of the phenomenon, its principles and role among public officers and policymakers across all fields (Siddiqqi and Jabbour, 2012).

Table 2 given below summarises the characteristics and limitations of the available assessment tools, currently employed for HSG by international organisations and some researchers.

Table 2: Characteristics and Limitations of Existing Assessment Tools for HSG

Framework/Assessment	Focus of Assessment	Characteristics	Limitations
UNDP Governance Assessment, 1997	Principles of GG	Wide acceptance of principles	General and not specific to health sector
WB Governance Indicators, Kaufman 2008	Governance performance at the national level	Results are expressed as summary measures employed to rank and compare countries	General and not specific to the health sector
WHO GG for medicine, 2009	Transparency	Combines quantitative and qualitative indicators	Specific to the pharmaceutical sector
WHO toolkit to monitor governance as a building block, 2010	Disease specific	10 rules-based indicators	Does not reflect the quality of HSG as a whole
Siddiqi Framework, 2009	10 principles of GG assessed at national, policy formulation, and implementation level	Qualitative indicators	Cannot assess the progress over time
Kirigi Health Development Governance Index, 2011	Based on Siddiqi's framework	Governance index based on 42 arithmetic indices	Complex and time consuming data collection process
Lopez Framework, 2011	Six building blocks and five selected GG principles; problem-driven approach	Qualitative indicators	No tracking of progress; no list of standard indicators; need to identify the problem to be assessed through another framework
USAID Framework, 2012	Leadership and governance at the national level	Qualitative indicators	No tracking of progress of governance over time; limited focus on leadership

Several frameworks have been developed for assessing HSG; however, these are not widely used still (Lopez et al., 2011). Pyone et al. (2017), in their systematic review, identified 16 frameworks for the assessment of governance in health systems (including accountability assessments as well). The authors found that only five of these have been

applied in practice as the others were found to be lacking the practicality needed or failed to achieve consensus with regard to their content. They concluded that there are gaps in the understanding of HSG, a lack of evidence as to the way in which it could be assessed in different settings, as well as a shortage of practical assessments.

Some assessments have been criticised for being overly general, for instance, those developed by the UNDP and WB, which have been designed to assess governance in general rather than the health sector particularly (Kirigia and Kirigia, 2011; Kaufmann and Kraay, 1999), thereby overlooking the specificity of health systems (Siddiqqi et al., 2009). While other assessments are specific, such as the GG for Medicine (GGM) assessment, this was developed by the WHO to assess governance in the pharmaceutical sector alone (WHO, 2009). Other assessments concentrate on a single aspect of governance, such as the degree of corruption (Lopez et al., 2011), neglecting other key principles such as participation, transparency, and accountability, among others that have been theoretically identified as significant. Furthermore, some frameworks that assess overall governance within health systems are designed to be disease-specific or to evaluate vertical programmes such as HIV/AIDS, as in the case of the WHO toolkit, which was developed in 2010 (WHO, 2010; Lopez et al., 2011). Lopez et al. (2011) assessed HSG using the problem-driven approach, collecting qualitative data for specific problems that prevent health systems from performing well (for example, workforce absenteeism). Hence, a limitation of this framework is that assessment has to begin from a weakness in governance that has been diagnosed beforehand (Kirigia and Kirigia, 2011). Though evaluating the specific weakness suggested by the tool can offer a focused appraisal of the limitation, other issues in governance remain unaddressed (Kirigia and Kirigia, 2011). Moreover, with its orientation towards problem-solving, a pre-identified weakness signifies that this framework does not contain a standard list of indicators or established criteria that could be applied consistently across different policy areas and that would thus allow accounting for multiple dimensions of HSG (Lopez et al., 2011).

According to Kirigia and Kirigia (2011), the "most comprehensive" framework to assess HSG to date is the one developed by Siddiqi et al. (2009). This framework, as mentioned previously, is organised around ten principles (Siddiqi et al, 2009). Despite its strengths, this assessment does not track progress or change, thus rendering comparisons between countries and assessment of improvement in governance over time within a given country difficult (Siddiqi et al., 2009). The authors suggested some modifications to the Siddiqi framework, in relation to the inclusion of a scoring system for inter-country comparison

with a proposed health development governance index (Kirigia and Kirigia, 2011). This index would contain the mean of 42 arithmetic indices. However, the calculation of these indices entails a complex and time-consuming process, necessitating the conduction of at least five national surveys, interviews with high officials in the focal country, as well as reviews and analyses of more than 20 national reports. Although it is important to have an assessment that can allow the assessment of changes over time, a practical assessment is as important as a meaningful and useful one.

1.1.6 Need for a New Assessment Tool

However, due to the limitations of the existing tools of health governance (Pyone et al., 2017), there is a lack of simple and practical assessments to assess HSG in different contexts. In this regard, various organisations/institutions assess HSG differently owing to their dissimilar definitions of it. Hence, there is a need for a new tool to address some of the limitations and help bridge some of the gaps in the existing knowledge. In addition, policymakers also need to use the tool as a diagnostic aid to signal deficiencies in governance that require to be addressed. According to the theoretical perspective, tackling HSG deficiencies might result in enhancement in the management of the health system, that might have a possible positive impact on its performance. Furthermore, it might also allow the effective exploitation of resources in contexts in which their availability is particularly limited.

In contexts in which governance in general and HSG in particular are perceived as important aspects of economic and social development (UNDP, 1997; Kaufman and Kraay, 2008), both in theory and as parts of the reporting mechanisms for international institutions and donors (Lopez et al., 2011; Siddiqi et al., 2009), robust and practical tools that facilitate the collection and evaluation of empirical evidence are vital to facilitate the understanding of HSG's operation in practice (Pyone et al., 2017). Hence, this research concentrates on the development of a *SMART* governance tool, capable of analysing health governance, in a Specific, Measurable, Achievable, Realistic, and Timely manner (Bell, 2004).

The rationale behind the inclusion of a SMART tool (the same behind SMART objectives) is to offer users of the tool a specific scope, which is clear, simple, and consistent. This would enable the assessment of governance principles in a concrete manner with available data sources to achieve the tool's objective in a realistic manner, without the necessity for a

large amount of resources (human, skills, and financial) and one that can be done in an acceptable time frame (Mannion, 1995).

As HSG represents a multidimensional concept (Barbaza and Tello, 2014), as discussed above, one way to assess it is performing an in-depth analysis of specific principles (Fryatt et al., 2017). Thus, the tool should assess good practices to reflect on good "enough" governance that should be in place to reflect on GG (Grindle, 2004) in the health system. Good practices "are actions, methods, initiatives or innovative practices that might contribute to and help enable improving the performance of a given process within the health sector. It can serve as a model/example that other countries can become familiar with, adapt to their context and use" (USAID, 2007,p.17). The suggested application of the tool will be discussed in detail in the following chapters.

The tool developed in this research will not be able to bridge all the gaps in theory and practice regarding HSG. This implies that it will cover only selected principles of governance, namely participation, transparency, accountability, use of information, and responsiveness (the following chapter will explain the reasons behind the selection of these principles).

Thus, a baseline non-exhaustive list of questions will be included to identify the most important aspects of these principles constituting GG. Although existing research suggests a positive association between HSG and systems' performance and health outcomes, this research considers what those selected GG principles would be and what would they mean for health systems seeking to adopt GG practices.

1.2 Research Question

How can the abstract principles of GG for health policy be rendered practically relevant to allow MoHs to assess their policymaking practices?

In order to address this question, this research has focused on the development of a tool that can be employed as a part of policymakers' repertoire. It is believed that it would enable them to learn about and reflect on existing practices in relation to the processes of governance.

To summarise, HSG entails a cross-cutting function that has been often neglected, partly because there has been no consents with regard to its definition. Consequently, existing

assessment tools fail to provide effective practicable means to determine what GG entails in the health sector. This research concentrates on the designing and development of a new tool to assess HSG as well as testing its practicality for use by policymakers in health authorities.

In chapter two, I present the research aim and objectives, purpose, and scope of the tool. Furthermore, I present the research design, which is in-line with the research objectives, with justifications for the approach selected.

Subsequently, in chapter three, I will offer a description of the way in which the selected principles were conceptualised through an examination of the literature for their key characteristics, their definitions, and the way in which they were operationalised into the first draft of the tool, by providing examples.

Furthermore, in chapter four, I explain the refinement and the development of the initial tool achieved through the Delphi consultations with experts conducted online. This would contain an explanation of the way in which the experts were identified and recruited, along with a description of the processes followed and how these experts refined the tool and their contribution to the content. In the last section in the chapter, I describe the review of the tool, undertaken by policymakers during a face-to-face consultation meeting and the importance of this feedback for modifying the methodology so as to enhance the tools' practicality and to enable the presentation of its results in a meaningful manner.

In chapter five, I discuss the pilot testing that was conducted to test the tool in a real setting. I provide the findings and recommendations presented to the national policymakers as well as the way in which the pilot demonstrated the tool's usefulness and its impact on the final adjustments in the tool.

In chapter six, I conclude with a reflection on the process that was followed to develop the tool, its contribution to the research, limitations, along with suggestions for future research.

Chapter Two

Aim, Objectives, Scope and Research Design

This chapter presents the aim, objectives, and the end product of the research. It includes the scope as well as justification for this research, the purpose of the proposed tool, its possible contributions and the context in which the tool can be employed. Moreover, this chapter outlines the initial planned research design and associates it with the objectives. The chapter concludes with a section concerning ethical issues that were considered and the ethical approvals that were secured.

2.1 Aim, Objectives, and End Product of the Research

2.1.1 Aim of the Research

The aim of this research is to address the research question presented in the previous chapter through the development of a SMART tool to assess HSG, i.e., in a Specific, Measurable, Achievable, Realistic and Timely manner (Bell, 2004), which can be utilised by policymakers to identify whether or not the characteristics of the selected governance principles (participation, transparency, accountability, use of information and responsiveness) are present, and if they do, the way in which they are reflected in policymakers' current practices in MoHs at the level of policy formulation.

2.1.2 Specific Objectives

1. To identify "key" GG principles and highlight their significance in health systems
2. To identify, based on the literature, the way in which these key principles were conceptualised and their primary characteristics
3. To operationalise these characteristics as they are applied in health policy formulation in a governance tool
4. To refine and further develop the tool using the Delphi method to gain consensus on key characteristics that need to be assessed and obtain policymakers' feedback to ensure practical application by end users.

5. To pilot test the developed tool with regard to its feasibility and practicality in collection of necessary data, usefulness of the results, and the recommendations to be generated.

2.1.3 End Product of the Research

The primary end product of this research is the Health Policymaking Governance Guidance Tool (HP-GGT). The secondary end product would be the methodological approach followed to develop a valid and practical tool that can be adopted by policymakers to assess HSG.

2.2 Scope of the HP-GGT

In light of the different levels of the health system in which governance plays a role, the several gaps involved in the assessment of HSG, and the difficulties entailed in addressing all these gaps in a single research study, the focused scope of this research in terms of level and unit of analysis, type of assessment, and the area of assessment has been presented in the following section.

2.2.1 Level of Analysis

The proposed tool is intended to assess "key" principles at the level of policymaking in health . Hence, the analysis of governance in policymaking in the health sector will take place at the national level. The decision to assess principles of governance at the level of national policymaking is founded on policymaking's role in shaping the population's health and as a major practice of MoHs in governance (LMG, 2012). This implies that health policy "constitutes those courses of action proposed or taken by governments that affect the health of their populations" (Blank and Burau, 2010, p.2). It refers to "all formal written documents, rules, and guidelines that present policymakers' decisions about what actions are deemed legitimate and necessary to strengthen the health system and improve health" (Blank and Burau, 2010, p.2).

The process of policymaking has been traditionally conceptualised according to different models and frameworks (Schlager et al., 2013). While many theories, models, and

frameworks describe the process, all of them share one aim, the simplification and explanation of the process's complexity to facilitate its understanding (Schlager and Weible, 2013). These different approaches have considered the policy process from different aspects, with the earliest work identifying the different stages the process undergoes (Hill and Varone, 2016). Others investigated the actors involved, inputs, outputs, outcomes, and the interactions of all these elements (Nowlin, 2011). Other researchers have investigated the structure, including the context, institutions involved, the rules, norms, and strategies that regulate these institutions and their impact on policy outcomes. Furthermore, others have also analysed the events or problems that led to the creation of policy processes or hindered them, or they considered a combination of aspects related to these matters (Schlager et al., 2013; Nowlin, 2011; Hill and Varone, 2016). Finally, other researchers have described the policy process as a consequence of a learning experience from the past or an external shock received by the system (Nowlin, 2011), with strong external drivers and an emphasis on contingency and politics in shaping the windows of opportunities for policy change (Nowlin, 2011; Mintrom and Norman, 2009).

Each theory highlights important aspects, components of the policymaking process, excluding a lot more. These frameworks entail a matter of deciding or highlighting the aspects that need to be prioritised. However, this does not imply that other excluded aspects are unimportant. This is done as no framework can take into account all aspects. Accordingly, one model of policy process had to be included in the proposed framework, and the policy cycle was selected. This model is the most widely used one for describing the policy process; it provided the baseline for other frameworks that emerged afterwards (Jann and Wegrich, 2006). It has served as the starting point for a considerable amount of research focused on policymaking (Jann and Wegrich, 2006). Specifically, the policy process cycle framework describes the chronological order of the different policy stages, including agenda setting based on the prioritisation of policy issues (including problem recognition and issue selection), policy formulation of health policies and decision making, policy implementation in practice, and monitoring and evaluation of the policy (Anderson, 1975). This framework provided a logical and "ideal" process, reflecting a continuous/circular and continuous policy process (Anderson, 1975). However, these assumptions concerning the policy process are not always true; often, there is no defined beginning or ending, and the stages overlap most of the times. Furthermore, sometimes, some stages are skipped as well, such as monitoring and evaluation, for instance Jann and Wegrich (2006). In the real world, different policy stages are not always distinct; they interact, overlap, and sometimes, even contradict each other in a complex and

unpredictable manner (Hallsworth and Rutter, 2011). Thus, despite its wide application and acceptance, the policy process cycle has received some criticism mainly in relation to it being a simplified and unrealistic model that does not specify actors, institutions, or problems involved in the policy process (Knoepfel et al., 2007). However, the policy stages model was used by other researchers as it was found to be relevant for assessing HSG at the national health policymaking level whether at the formulation or implementation stage (Siddiqqi et al., 2009; Kirigia et al., 2011).

The proposed tool will focus only on the policy formulation stage of the health policy process (implementation was included in the original plan and was subsequently removed as it was thought that its inclusion would make the research too extensive given the mandated size of the thesis). It is acknowledged here that in real practice, it is difficult to separate formulation from implementation due to the overlapping of these steps and the actors involved; furthermore, a key limitation of the tool is that it is not linked to other stages of the policy cycle. However, it is not uncommon to focus on a particular stage of the policy process rather than on the whole policy cycle (Howlett, 2011). Concentrating on a single stage of the policy cycle was found to be useful for improved understanding of that stage as it offers details concerning its importance, as a prerequisite to other stages as well as its influence on subsequent stages and policy outcomes (Warghade, 2015; Sidney, 2006). This does not imply that the other stages are not as important as a given stage. However, the stages of agenda setting, implementation, evaluation, and monitoring fall beyond the scope of this research and can be assessed in future research.

The policy formulation process is a complex and essential stage in the policy process as it concerns transforming all issues prioritised during the agenda setting stage into a policy/plan or a programme to be implemented (Turnpenny et al., 2015; Jann et al., 2006). Policy formulation involves determining the objectives of the policy and the way in which these objectives can be achieved, whether formally, in terms of relevant legislation and regulatory frameworks, or informally (Sidney, 2006). It also includes the collection and analysis of relevant information, using evidence, building networks with all relevant stakeholders, and resolving any conflict that may arise between the different actors who are affected by the policy, whether in a positive or negative manner (Hill, 2013). Thus, policy formulation constitutes “a critical phase of the policy process” (Sidney, 2006). Moreover, policy outcomes most likely depend on the process that was followed to formulate the policy in question (Sidney, 2006). If policies fail, the consequences might be substantial with respect to health outcomes and people’s trust towards their governments (Hallsworth

and Rutter, 2011). Assessing the policy formulation phase using policy formulation tools can help improve the future policymaking process (Sidney, 2006). Thus, following a good policymaking process should be an aim in itself for policymakers (Hallsworth and Rutter, 2011), who usually do not acknowledge the importance of the quality of the process (Hallsworth and Rutter, 2011). Moreover, limited research has been undertaken to evaluate the way in which policies are formulated (Howlett , Tan, Migone, Wellstead and Evans, 2015).

Practising GG at the policy formulation level is essential because it has the potential to impact all other stages of the policymaking process (Howlett et al., 2015), given that all other factors that might affect the policy process remain unchanged. This research approaches the policy formulation as a matter of simple incremental analysis, a limited analysis of one policy stage (or it could be an analysis of a single policy goal, alternative, or consequence) (Lindblom, 1979). The incremental analysis is usually employed when the aim is to understand a complex subject that entails a large number of processes and factors focusing on partial or one aspect of the process under evaluation, which is a common practice (Lindblom, 1979). This is true for this research, which focuses only on policy formulation and the five principles of GG.

Policy formulation tools are generally employed to assess practices and processes at the policy formulation level to help policymakers identify strengths and weaknesses and thus improve future policy formulation processes (Howlett et al., 2015). The policy formulation tools used in the health sector and in other fields range from brainstorming, consultation exercises, expert judgments, focus groups (extremely flexible methods with no standardised processes), to risk analysis, checklists, scenario analysis, cost-benefit analysis, and cost-effectiveness analysis (based on rigid structures, standardised methods, and equations) (Howlett et al., 2015). This research involves the introduction of a "new" policy tool, namely the HP-GGT. I would classify the HP-GGT as falling between these two categories of tools as it combines expert opinion and is also based on checklists (this will be discussed in detail in the section below). This implies that it is a practical tool, yet it is based on a list of GG/good quality policymaking characteristics developed by drawing on the literature and experts' consensus.

The intention was to design a tool that was sufficiently flexible to allow the analysis of the governance processes involved in the policymaking of any type of health policy, which has been recently formulated and implemented in a country. The tool is generic in terms of the policy type, and it will focus on the policy process and not the content of the policy or its

technical capacities; it concerns assessing the policy formulation process from the perspective of governance. It is not claimed that the tool is universally applicable; however, it is sufficiently flexible to allow a few adjustments so as to make it relevant to the context of the country it will be used in. The tool needs to be deployed in different countries with different contexts to ascertain whether it is practical and applicable. It can be used to initiate change (Mintrom and Norman, 2009), identify weaknesses if there are any, and thus, facilitate the improvement of the policy process (Mintrom and Norman, 2009). It can help inform policymakers about ways to improve the policymaking process, but it cannot control the context in which the policy formulation takes place. This tool can be employed as an instrument for reflection, that is, it is recommended that policymakers reflect on the way they take actions; reflexivity is necessary on the part of policymakers, yet it is rarely exercised (Hallsworth and Rutter, 2011). In sum, the tool will help policymakers consider their policymaking practices and their relation to the list of "good practices" contained in it.

The complexity involved in processes of health-related policymaking and improving the policy formulation process has been recognised (Hallsworth and Rutter, 2011). However, the betterment of one aspect (governance structure at the policy formulation level) can lead to the enhancement of the other aspects as well as the process itself and can thus contribute to improved outcomes in implementation (Knoepfel et al., 2011; Fryatt et al., 2017).

2.2.2 Unit of Analysis

MoHs or health authorities should play the most important role in governance in the health sector. Health governance is related to MoH or health authorities' capacity to formulate and implement policies effectively (WHO, 2009), oversee the overall health system, encourage stakeholder participation, be responsive to the population's needs, as well as ensure regulations, accountability, and transparency (USAID, 2012). MoHs/health authorities are responsible for promoting and maintaining the well-being of the population through their role in the regulation and policymaking (Veillard et al., 2011). Hence, the unit of analysis for this study will be the MoH or health authority (whether at the central or the peripheral level in decentralised systems) in a given country. This assessment will evaluate MoHs or health authorities' ability to fulfil their function in health governance in practising GG in the formulation of health policies. It will assess MoH or health authority-led policymaking processes. The influence of contextual factors (discussed below) on

policy formulation cannot be overlooked, especially in developing countries (Warghade, 2015), and thus, it will be covered through perception-based questions (also discussed below).

As stated here, the scope of the tool entails focussing on the way in which MoHs or health authorities facilitate and steer the policymaking process, which signifies paying attention to their procedural capabilities (processes and inputs) (Fukuyama, 2013) and not performance (output/content of the policy) (Rotberg, 2014). Furthermore, Fukuyama (2013) suggested that there are four approaches to assess governance in the domain of public policy, and these are procedural measures, capacity measures, output measures, and bureaucratic autonomy. The study of procedural capacity aims to shift the attention from measuring only the health system's performance and service delivery outcomes (for which, an enormous number of assessments are available (OECD, 1998; 1999; AHCPR, 1999; Knowles, Leightan and Stinson, 1999; Murray and Frenk, 1999)). The evaluation of the "execution" process and health authorities' ability to perform one of their essential functions, policymaking (Fukuyama, 2013; Rotberg, 2014), has not been given much attention by international organisations.

This assessment will be used as a guidance tool to identify the strengths as well as weaknesses in the practise of governance, prioritise key areas for improvement, and offer practical recommendations for the institutional strengthening of MoHs/health authorities to enable them to perform their function. The tool can be utilised by policymakers in LMICs or by international organisations interested in improving the governance of policymaking at the national level as a step toward the enhancement of HSG in practice. In conclusion, the potential targeted users of this tool are policymakers in the government sector, specifically, those within MoHs or health authorities.

2.2.3 Context of the Analysis

Since the level of analysis involves the national policymaking process, contextual factors and the policy environment that affects the health policymaking process should be closely examined. These contextual factors include political, economic, social, cultural, historical, local, regional, national, and international factors (Walt and Gilson, 1994; Buse, Mays and Walt, 2012). These factors affect the environment in which HSG operates and render the policymaking process complex (Buse et al., 2012). In general, LMICs are known for their political instability or uncertainty, disrupted operation of the health sector (due to wars and

natural disasters), constant reforms, state bureaucracy, economic constraints, strong cultural influence, weak institutional capacities, weak regulatory and legislative systems, strong private sector, inter-dependency of international funding and technical cooperation, influence of global threats, foreign policy, relationship between administrative (civil servants) and political decision makers, power struggles between "winners and losers" due to the policy, and lack of evidence-based information to inform policy (Walt and Gilson, 1994; Gilson and Raphaely, 2008; Walt , Shiffman, Schneider, Murray, Brugha, and Gilson, 2008; Buse et al., 2012; Hill et al., 2016). ` the same policymaking and governance style. These contextual factors can affect the policy making process positively or negatively (May and Jochim, 203) and thus should be taken into consideration (by both researchers developing governance assessment tools and policymakers who wish to assess it) in the evaluation of the policy processes and HSG as they reflect on the reality of HSG's application. In this research, I suggest that the tool can be applied in more than one context and by different countries.

2.2.4 Type of Assessment

It is important to track progress and improvement in the quality of governance over time (Buckingham, 2004). This is necessary to enable the identification of the elements that are present or absent or practised or not practiced in relation to governance. However, this assessment would offer only a crude analysis of the complex phenomenon that requires further exploration. Taking into account the contextual factors (discussed above) that will affect the environment in which HSG processes are realised is essential in any assessment of governance to complement our understanding of the way in which things work in practice (Reeves et al., 2008; Bryman, 2016). The assessment tool is designed to track progress and improvement over time as well as offer an explanation of factors that contribute to the quality of governance, based on checklists after interviewing knowledgeable key informants (KIs) regarding these practices and their responses, which would be validated by supporting evidence. The tool will be based on evidence collected through relevant document analysis, and the list of documents reviewed will be included in the final report of the assessment to offer a verification of the findings/conclusions if required (for instance, by donors to ensure that the claims of GG practices are valid). This will provide context-free summaries of governance practices, thus allowing the tracking of change over time. Using simple tools that include checklists and questionnaires (such as HP-GGT) for policy formulation analysis is a common practice (Turnpenny et al., 2015).

Furthermore, the tool will also be able to capture the context in which HSG operates by asking the same KIs regarding their perceptions of the governance process and factors that affect policymaking.

2.2.5 What Will Be Assessed?

According to the framework developed by Siddiqqi et al. (2009) (the most comprehensive one to date, as discussed in chapter one), there are 10 principles (also mentioned there) relevant to health sector. This framework has undergone international peer review and thus enjoys a high level of conceptual agreement among experts in the field (Siddiqqi and Jabbour, 2012). The thoroughness of this framework and its principles have been documented by others (Kirigia and Kirigia, 2011; Lopez et al., 2011). Hence, it forms a logical starting point for this research . However, this research will focus on only five key principles of governance: participation, transparency, accountability, use of information, and responsiveness. In this subsection, the rationale behind the selection of these five principles has been given.

This decision was made, primarily, for reasons of practicality: I had to determine an "acceptable" number of principles to focus on while ensuring that the scope of the tool was not too narrow or wide. Certainly, other studies have reported the average number of principles investigated as five (Ruhanen et al., 2010). Second, I decided to focus on "key" principles based on their importance in the health sector as reported in literature. According to Siddiqi and Jabbour (2012), the key principles of governance in a health system include participation, transparency, and accountability. Nearly all the existing assessments acknowledge the importance of these three principles for HSG (Barbaza and Tello, 2014). Participation is believed to enable citizens to influence decisions that concern the health services they receive and consequently their health, which can result in improved health outcomes in the long run (Labonte, 2010). Transparency is considered an important component of any reform as it is critical to policymaking, resource allocation, health performance, and increased accountability (NAO, 2012). Accountability has been found to be an issue that needs to be addressed in public health governance since it is usually neglected despite that fact that it has direct implications in the performance of health systems (Marks, Cave and Hunter, 2010). Increasing accountability within the health system will ensure the proper utilisation of resources, leading to improved service

delivery (Brinkerhoff, 2004). The presence or absence of these principles itself serves as an indicator of other governance principles (Barbaza and Tello, 2014).

Ciccone et al. (2014), based on a literature review concerning the possible association of governance mechanisms to health outcomes, concluded that "encouraging participation and applying accountability at all levels of the health system may be more likely to improve health" (Ciccone et al., 2014, p.94). This assumption regarding the association needs to be further explored by more research in order to confirm the type of relationship between governance principles and health outcomes.

The generation and use of information allows transparency in addition to the promotion of evidence-based practices (Lavis , Posada, Hanines and Osei,2004). Hence, the assessment of the utility of information within the health systems is as important as the assessment of transparency as the former is considered a part of the latter. In addition, the organisational capacity to collect and disseminate information is essential for any policy formulation process to produce evidence-based policies (Howlett and Ramesh, 2016). According to Fryatt et al. (2017), particular attention should be given to the generation and dissemination of information due to the asymmetry of information among all stakeholders in the health sector, policymakers, the private sector, and the public (WHO, 2009). Responsiveness is considered a basic human right, indicating that by catering to the legitimate needs of people will help improve their well-being, which is a goal of health stewardship (Gostin, Hadge and Valentine, 2003), one that is not frequently assessed (Darby, Valentine, Murray and Desilva, 2000, p.2).

Apart from the assumption that improving governance might have a positive influence on the health system' performance and its outcomes eventually, it also might have a positive effect on the policymaking process itself. According to the Institute for Government's report on "Making Policy Better", seven elements are essential for an effective policy formulation process: proper engagement, setting roles and accountability mechanisms, transparent goals and ideas (Hallsworth and Rutter, 2011). Encouraging participation in the policy process might facilitate building public trust in the process and the subsequent decisions (Bevir, 2008). Accountability, transparency, responsiveness to the public's needs, and consensus of all involved contribute to the quality of public policymaking (Bevir, 2008). Additionally, the public policy process should be open and based on evidence (Hallsworth and Rutter et al., 2011). Evidence-based policymaking involves the collection as well as the dissemination of information that will be used in the formulation, implementation, and evaluation of policies (Howlett et al., 2016). Applying these

principles at the policymaking level might result in improved policymaking (Hallswarch et al., 2011). Furthermore, practising GG at the policymaking level might result in an enhanced policymaking process, which is valuable for the policymakers themselves, even if it does not lead to in better health outcomes.

Again, focusing exclusively on the application of these principles in policymaking does not imply the constraints of practical implementation and the role of politics in policymaking has been left unacknowledged; it has been done to gain a simplified perspective in order to have a starting point for improving the quality of health governance at the national level.

Hence, the five principles (participation, transparency, accountability, use of information and responsiveness) were selected after conducting the literature review, in which these presented the most emphasised ones. This fulfilled objective one of the research which is to identify key GG principles and highlight their significance within the health system. According to Bovarid (2005, p.223), "all GG principles are important, however, they are not all equally important to all stakeholders in all contexts". Additionally, it is not necessary that all of these principles will lead to the resolution of all governance problems because in practise, they do not work in isolation, in the absence of other GG principles that have not been discussed in this research (such as rule of law, ethics, and other principles).

As discussed in chapter one in relation to the definition of GG in terms of its principles and the approaches adopted by various organisations to "list" what constitutes governance, I decided to take this approach a step further in this research to explain the selected principles in further depth to facilitate assessment and understanding. This result is consistent with the recommendation of the systematic review conducted by Pyone et al. (2017), which stated that there is a need to explore the principles of GG extensively to gain a better understanding of HSG.

Not all questions included in the tool will be relevant or applicable to all different countries as it has been developed as a generic tool and can be adjusted based on the context. The aim is not to have a perfect tool but a good, usable and useful tool. The tool will cover only a sub-level (health policymaking at the MoH level) in which health governance has a role, as discussed in this chapter.

This study can be considered as a pilot for the development and construction of an assessment of the five focal principles; the same approach can be adopted to develop assessment tools for the remaining principles at a later point.

2.3 Purpose of the Tool: Its Contributions and Implications

The purpose of the research is to offer a practical tool that can be employed to assess the way in which MoHs or health authorities are governing the health policymaking process as well as offer a roadmap regarding ways to improve the process. This tool will be useful for policymakers in identifying the weaknesses, detecting changes, and demonstrating progress (WHO, 2010).

The use of such a tool can be perceived as a starting point for creating a policy dialogue between policymakers and other stakeholders regarding an important, sensitive issue , with the aim to promote GG/practices, initiate and enable change, as well as offer a learning opportunity for all involved (WHO, 2009).

The contribution of the tool is a focus on selected key governance principles and their major characteristics identified in the literature, which are aimed at promoting a common understanding of governance principles and their major characteristics. Specifically, a literature review was performed to determine the major characteristics and relevant concepts of the selected governance principles, which are directly relevant to the health sector, to gain a better understanding of the way in which these principles can contribute to the quality of HSG at all levels (a summary of the findings from the literature search will be presented in chapter three). The purpose of this step was to go beyond the traditional approach of merely listing the relevant principles of governance, by exploring their primary characteristics and components for better conceptualisation. The main characteristics of the principles are readily available in the literature; however, they are not employed comprehensively in other health governance assessments. This research attempted to compile the central characteristics that need to be validated during the Delphi consultations (discussed in chapter four). The characteristics identified for each governance principle provided a definition of that principle and was thus utilised as a guideline for best practices to be followed to achieve GG (see chapter three).

It is expected that the use of the tool will encourage participation, transparency, accountability, and use of evidence. It will facilitate the identification of critical weaknesses and gaps that need to be addressed and improved at later stages. Furthermore, it should be considered as a guidance tool as well as an instrument for assessment. It does not only evaluate whether GG principles are practiced or not but also offers guidance regarding a list of "good practices" that can be followed to improve the quality of HSG at the policy formulation level. In conclusion, the developed tool is based on a checklist of

good practices that can be followed to enhance the quality of governance, and it is expected that it will produce evidence regarding the way in which policymaking processes are realised (Warghade, 2015).

2. 4 Research Design

The research design involved a step-wise approach, focusing on the development and testing of the tool (see Figure 1 for the initial research design).

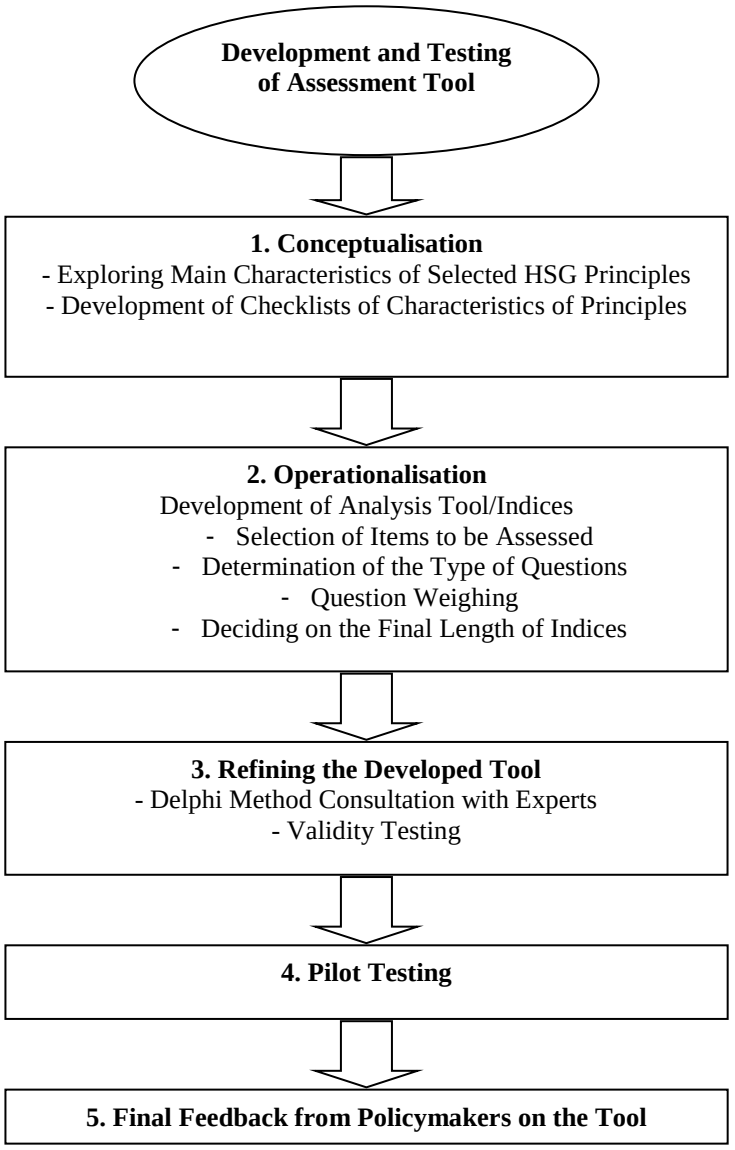

Figure 1: Research Design

The following subsection contains an outline of the initial planned research steps, which is accompanied by justification for these, the following chapters will comprise detailed description of the methodology in detail.

The initial study design included five steps that have been grouped into three stages.

2.4.1 Conceptualisation of the Principles of HSG

The diversity of the definitions of governance renders it a "conceptually rich" subject.

Moreover, governance cannot be measured directly due to the lack of tangible criteria that can be included for comparison (Andrews, 2008). However, various agencies/organisations that deal with governance have identified different lists of principles that contribute to its quality and the reason behind it being classified as "good governance" (UNDP, 19; USAID, 2008; WHO, 2009). Governance has been defined as a set of interrelated principles. Detailed knowledge regarding governance and its principles forms an essential step in the development of a valid and usable assessment tool (Devellis, 2003). Conceptualisation is a standard step employed in the social sciences, especially with concepts that are abstract and ill-defined (Mueller, 2004), such as governance.

I decided to work on the conceptualisation of the principles due to the lack of a common understanding of what each principle entails in practical terms and the way in which they can be applied at the level of health policymaking. This step was critical to this research to identify the central characteristics and aspects of the key principles. This step is required to fulfil the second objective, understanding from the existing literature the way in which these key principles and their primary characteristics are conceptualised (details in chapter three).

2.4.2 Operationalisation

The step following the conceptualisation was focussing on the operationalisation of these principles in a manner that would enable their assessment (Devellis, 2003). Operationalisation of governance and its principles should reflect a theoretical understanding of these concepts, thus advancing from abstract concepts to assessable variables (Mueller, 2004). In order to operationalise the principles that need to be assessed, appropriate questions should be developed for inclusion in the tool.

Since governance is a multidimensional concept and its principles, in turn, have various defining characteristics, it cannot be assessed with a single measure; rather, multiple/composite measures are required, which can supply rigour to the analysis (Mueller, 2004). Accordingly, an index was required for each of the governance principles selected. Each index would comprise a list of questions that cover the primary characteristics/key elements of these principles, which are summarized in the checklists developed as a part of the conceptualisation step (further details are provided in chapter three) (Devellis, 2003). This operationalisation step enabled the proposal of an initial draft for the tool, thus fulfilling objective number three, the operationalisation of these characteristics as applicable in health policy formulation to facilitate assessment.

2.4.3 Refinement and Further Development of the Tool

The Delphi method was identified as the most suitable way to refine and validate the tool; it forms a recommended research approach in concept/framework development (Okali and Pawlowski, 2004), which is the case in this research. The Delphi method was introduced in the 1950s as a technique when experts' consensus was required on a complex issue (Hasson, Keeney and Mckenna, 2000; Okali and Pawlowski, 2004). It has been utilised in many fields, including business and management, information systems and technology, defence, industry and commerce, education, medicine, as well as, nursing and health (Kirigia, 1997; Kalaian and Kasim, 2012). It constitutes a suitable research method for studying complex subjects that have a limited number of experts (Okali and Pawlowski, 2004), such as governance, and maximising the content validity of a newly developed tool (Devellis, 2003). It is considered a flexible and appropriate method that does not require a face-to-face meetings of expert panels; discussions can be conducted virtually (Okali and Pawlowski, 2004).

This method is employed to seek experts' opinions in order to gain a better understanding of the concepts (Okali and Pawlowski, 2004) underpinning the topic under study and other useful information. Since there is a lack of standard assessment tools and no consensus on the normative principles of HSG, I decided to further refine my initial tool through this method. The Delphi method was also selected due to other reasons. First, it allowed gaining consensus regarding what constitute good practices for the principles of governance. Second, it could provide insights regarding the way in which these principles relate to policymaking processes and practices (Okali and Pawlowski, 2004). Third, the

choice of the Delphi method over other means of face-to-face discussions or interviews was made with the aim to involve as many governance experts as possible from all around the world at the minimal possible cost. The detailed Delphi process will be discussed in Chapter Four.

Developed assessment tools should be valid and reliable (Mueller, 2004). The individual questions as well as the tool as a whole require to be valid and reliable in different contexts. We needed to test if the conceptualisation appears meaningful to others.

- *Validity Testing*

The developed assessment tool should correctly capture the concepts it is intended to assess with minimum bias possible (Mueller, 2004). The developed tool was subjected to a series of validity tests, including face validity, content validity, and construct validity (which will be discussed in Chapter Four).

2.4.4 Pilot Testing

Pilot testing of the developed tool represents an important step, conducted to assess its feasibility in practice, in terms of consistency, ease, and speed of data collection, among other things (Campbell et al., 2003), and it pertains to fulfilling objective five of this research. Piloting is a key test for the tool's applicability/utility in real settings (Campbell et al., 2003). It was conducted in Lebanon, which is classified as a middle-income country, and where, as a resident and worker in the health field, it was practical to conduct this test. Details of the pilot testing have been offered in Chapter Five.

- *Reliability Testing*

A reliable tool is one that produces the same results when repeated with minimum error (Mueller, 2004). To be reliable, a tool should exhibit internal consistency (Devellis, 2003). In other words, the questions included in the tool should be homogenous and inter-correlated to each other (Devellis, 2003). The questions should be causing each other or have a common root cause to prove that they assess the same principle (Devellis, 2003). There are several methods to test reliability, which should be ascertained as a part of the pilot phase, as explained in chapter five. Other factors such as acceptability and the opinion of KIs were also tested (Campbell et al., 2003) during the pilot test.

2.4.5 Final Feedback on the Tool

A consultation meeting was conducted in the presence of some of the Delphi experts who were consulted in the initial research and others in order to present the final tool. This is known as the RAND method, which involves combining Delphi consultations with a subsequent face-to-face panel meeting for the final evaluation of newly developed assessment tools in order to ensure quality (Campbell, Braspenning, Hutchinson and Marshall,2003). The details of the consultation meeting will be discussed in Chapter Four.

2.5 Ethical Considerations and Approvals

As mentioned earlier, the study involved consultations with Delphi experts during the refinement phase of the tool, data collection through a desk-based review of pertinent documents and interviews with relevant stakeholder KIs in the health sector as part of the pilot testing phase. Hence, no significant ethical issues were anticipated. Although the Delphi experts were told the names of other experts who were willing to participate, their responses were kept anonymous, and hence, quasi-anonymity was maintained. The experts' consent to these measures and whether their names could be published in the final thesis was requested through email. They were also informed that even if they agreed to participate, they were free to withdraw at any time during the Delphi process.

Additionally, the research included interviews with relevant KIs as part of the pilot. An official letter or email was sent to these potential participants for permission for an interview with an explanation of the purpose behind the test. The letter included a request for informed consent to participate in the pilot. It also stated that confidentiality and data protection would be respected throughout the study.

At the beginning of each interview (during the pilot test), the participants were asked to read and sign an informed consent form. They were assured of confidentiality and were informed about the right to withdraw at any time during the interview. Permission was requested to record the interview on tape. Furthermore, consent was requested from each participant to contact them in the future if necessary for further clarification or triangulation of the results obtained. The participants were also informed about the way in which the data would be stored and used. In this regard, the questionnaires, signed consents, audios, and other field/interview notes were physically stored in a secure manner,

and only the principal investigator had access to them. The other study documents will be stored for at least three years after the end of the study. The answers of KIs were coded, and no identifiable information related to the participants was recorded. Hence, no link can be made between identifiable information and participants' coded responses.

The study involved obtaining and processing personal data related to the participants, (e.g. recording interviews with them), and hence, the Data Protection Act 1998 had to be adhered to throughout the research. Lastly, the results reported in this document and any other publications were guaranteed to be anonymised.

Lebanon does not have a formal national-level ethical committee for research approval. Hence, a proposal was submitted to the Lebanese MoH, and the approval to conduct study was obtained in writing. An application for ethical approval was also submitted to the School Research Ethics Approval Panel (SREAP) at Bath University and was secured as well.

To summarise, this chapter has presented the aim, objectives, and purpose of the research, the scope of the proposed tool, as well as an explanation of the research design.

In the following chapters, chapters Three, Four and Five, I discuss the five steps and explain the way in which the research design was executed as a three-stage process. Furthermore, a description of the way in which the different research phase contributed to the tool in terms of content, structure, and methodology to conduct the tool.

Chapter Three

Developing the Assessment Tool

This chapter explains the purpose of the first phase of the research, the conceptualisation of the governance principles and the way in which this was accomplished through the literature review. Additionally, this chapter includes descriptive summaries of the findings of the literature review rather than a critical analysis. It also includes the checklists and the framework proposed, both of which guided the operationalisation of the principles and their component elements as well as the way in which they were transformed into concrete questions that formed the first draft of the tool.

3.1 Conceptualisation of the Principles of Health System Governance

This chapter identifies the concepts and characteristics found in the wide range of literature that covers governance principles as a first step towards achieving a better understanding of the principles that constitute GG. Detailed or in-depth conceptualisation of the concepts under study can strengthen the tool's validity (Mueller, 2004). Not only is governance a broad and relatively abstract term, its principles can have different implications (Barbaza and Tello, 2014), that is, their application can signify different things to different people, which presents a major challenge in the development of a tool to assess these principles. As discussed in Chapter One, the primary characteristics of the principles are readily available in the literature; however, they are not explored in depth nor used extensively in the health governance literature. A literature review, conducted to compile and summarise the findings, included searching for the concept of governance and its selected individual principles in the literature on health and other fields in general as well as considering health policymaking specifically.

3.1.1 Search Strategy Employed

The search was limited to articles written in the English language, and the following databases were searched: PubMed, Scopus, Embase, Web of Science, Social & Political Policy, Cochrane Library, and Google Scholar. The literature review was conducted using

different terms for governance, including governance, governing, stewardship, and leadership.

First, a search was conducted with governance-related terms in combination with definitions, frameworks, models, assessment, measurements, and indicators; the aim was to identify articles from different fields. Then, these were combined with terms related to the health sector, such as health system, healthcare, health reform, health system strengthening, health system performance, and health policymaking. Subsequently, the governance terms were combined with relevant terms related to principles, including elements, components, concepts, attributes, aspects, accounts, domains, and dimensions. Various combinations of key words were utilised with "AND, OR".

After nearly a year of researching on governance in general, I decided to focus the tool around the five principles mentioned earlier (based on reasons discussed in Chapter Two), and thus, the literature search was further expanded to include term. The search terms used were:

- For participation: Participation, engagement, representativeness, active citizen, community participation, multi-disciplinary participation, partnership, citizen voice, consensus orientation, stakeholders, interest groups, involvement, collaboration, inclusive, and coalition building;
- For transparency: Transparency, openness, and disclosure;
- For accountability: Accountability, oversight, answerability, and sanctions;
- For use of information: Information, intelligence, research/research-informed, research utilisation, evidence-based, knowledge management, and knowledge translation;
- For responsiveness: Responsiveness, responsive, population/public requirements, and legitimate requirements.

Furthermore, the search terms employed were combined with governance (as well as other relevant terms), health (combined with other relevant terms), as well as the terms policy, policymaking, and policy formulation.

The websites of international organisations were searched, including those of WHO, UNDP, WB, and USAID. Finally, a manual search for citations of the identified articles was conducted. Based on this search, the conceptualisation of the principles and their characteristics were identified and have been detailed below.

In the following section, I have summarised the findings from the literature concerning different aspects of governance principles that I found relevant to health policymaking. The characteristics/components outlined below represent the "ideal" norms of governance principles that should be promoted to achieve GG. These characteristics/components cannot be easily implemented in real-world practice due to a lack of understanding concerning exactly what and the way in which they contribute to the quality of governance, difficulties involved in the application of abstract concepts in practical terms, and the negative aspects that may be associated with their application. The negative aspects have been discussed at the end of each principle's coverage. This research involves conceptualising these characteristics/components in a simplified manner to allow their assessment and enable policymakers to implement them to the extent possible. The summaries given below does not emphasise what is more important, more central, or vital out of these aspects for inclusion in the assessment. The critical analysis of the different aspects was undertaken during the Delphi consultations with experts in governance.

3.1.2 Participation

- *Definition*

Participation is all about empowering communities/citizens to exercise a role in decisions that affect their lives and in the policymaking process to reach common goals (Labonte, 2010). It involves the ability to work together effectively and create a space in which groups with varied interests and roles have an opportunity to participate, voice their position, and negotiate policies (Dieleman, Shaw and Zwankkon, 2011). Siddiqi et al. (2009,p.18) stated that "all men and women should have a voice in decision-making for health, either directly or through legitimate intermediate institutions that represent their interests. Participation is associated with freedom of association and speech, as well as abilities to participate constructively when possible on health policies and procedures".

- *Types of Participant*

It is important to identify the potential participants in policymaking before describing the participation process and the factors that affect it. Since the assessment will be concerned with governance at the level of health policymaking (formulation phase), theoretically, all actors involved in this sector should participate in the process. Mutale, Mwanamwenge, Balabanova, Spicer and Ayles (2013) wrote about three major categories of actors in any health system: government/state actors, providers, and beneficiaries/clients. USAID (2008)

further clarified these three categories. State actors include politicians, policymakers, and other government officials (including high and middle-level officials), in addition to public health sector agencies such as MoHs, health and social insurance agencies, as well as public pharmaceutical procurement and distribution entities (USAID 2008; WHO, 2009). Other public sector actors apart from the health sector include parliamentary health committees, regulatory bodies, ministries of finance, various oversight and accountability entities, and the judicial system (USAID, 2008; Labonte, 2010). Health service providers include a mix of public, private, and voluntary sector providers working in a variety of institutions, such as hospitals, clinics, laboratories, and educational institutions in addition to other organisations such as insurance companies, health maintenance organisations, pharmaceutical industry, equipment manufacturers, and suppliers (USAID, 2008). Beneficiaries are service users/patients, guardians of patients, and the general public (Brinkerhoff and Bossert, 2008; Mitton, Smith, Peacock, Evoy and Abelson, 2009), laypersons, and taxpayers (Papadopoulos and Warin, 2007). Other diverse groups of actors who can contribute to policymaking include journalists (media), academia/researchers, think tanks, champions, non-governmental organisations, advocacy groups, and interest groups (who are directly or indirectly affected by a given policy) (Brugha and Varvasovszky, 2000; Bennette, Corluka and Aikins, 2012; Smith and Katikiredali, 2013). Further people who may have a role in the health sector, as mentioned in the literature, includes donors/funders, who might have a role in policymaking process at the national level (Dieleman, Shaw and Zwankkon, 2011), vulnerable groups (poor and marginalised factions of the society) (Brinkerhoff and Bossert, 2008), and women.

Thus, the proposed tool needs to identify the types of participants, for policymakers and health authorities, that need to partake the process. However, an assertion of prominence among participants and the various roles that they might play in the process of policymaking is beyond the scope of the tool.

- *Benefits of Participation*

The importance of participation with regard to different aspects of health for policymakers and other stakeholders has been reported in the literature (Monza and Cook, 2002; Papadopoulous and Warin, 2007; Labonte, 2010; Dieleman, Shaw and Zwankkon, 2011). It allows participation in the health sector, in general, and in the policymaking process, in particular, with numerous advantages. Dieleman et al., (2011) assert that it ensures the ownership of policies and promotes a sense of responsibility to influence the policymaking process and play an active role in the implementation phase later on. This view is further supported by Manza and Cook (2002) and Labonte (2010), who suggest that participation

accords citizens their right to influence policies that can affect their health and can thus result in improved health outcomes. Papadopoulos and Warin (2007) further add that participation might result in a more efficient policymaking process due to the contribution made by knowledgeable actors regarding the policy concern, which will result in enhanced policy decisions and actions that may lead to more effective outcomes due to the involvement of concerned stakeholders. Hence, by increasing the effectiveness and efficiency of the health policy process, a population's health can be positively affected (Matthews, Pulver and Ring 2008; Smith and Katikiredeli, 2013). However, while the participation of a broad group of stakeholders is usually accepted as a potentially beneficial aspect, it is rarely encouraged in practise (Mutale et al., 2013).

A top-down approach in policymaking can possibly result in the failure in implementation of the determined course of action (Papadopoulos and Warin, 2007). The top-down approach implies that not all policy actors are involved or consulted and indicates a lack of proper representation, consultation, and communication in the formulation of policies (Matthews, Pulver and Ring, 2008). A lack of participation might obstruct the policy cycle as it can slowdown the implementation with resistance to change, which can emerge from health professionals, service providers, unions, and others, factions who were not included in the process (Dieleman et al., 2011). Stakeholder participation can increase the level of policy acceptance by health professionals (Papadopoulos and Warin, 2007). Additionally, including the public in policymaking is considered a tenet of democracy (Papadopoulos and Warin, 2007; Bishop, Vicary, Browne and Guard, 2009). In conclusion, governments can benefits in numerous ways by encouraging the participation of various stakeholders, which include increased knowledge regarding the concerned policy issues, certainty of having sufficient expertise and capacity required in the implementation phase, as well as assured compliance of all relevant stakeholders (Papadopoulos and Wein, 2007).

- *Mechanisms to Enable Participation*

However, given the advantages, the way in which MoHs can engage and encourage the participation of various stakeholders remains a challenge as it calls for proper planning and resources (Lavis et al., 2004). Currently, some countries are applying innovative participatory tools for policymaking, including public inquiries, the right to know legislation, citizen juries, policy dialogues, impact assessment with public comment, regulatory negotiation, mediation, and other kinds of third-party facilitated conflict resolution (Papadopoulos and Warin, 2007). The efforts of governments to promote participation also include partnership, contracts, roundtables, inter-governmental

conferences, and committees (Papadopoulos and Warin, 2007). Furthermore, offering incentives for participation can also be adopted as a strategy (Brinkerhoff and Bossert, 2008). Again, the aim was not to determine superior mechanisms or to present the advantages and disadvantages of each; rather, the aim was to highlight some mechanisms that can enable participation that can be utilised, whether formal or informal.

- *Factors that Influence Participation*

There are several factors that can affect (positively or negatively) the various stakeholders preparedness to participate in the policymaking process as well as affect the "ideal" participation in the process itself. These factors can become obstacles or facilitators to participation, depending on the context and situation. Policymakers need to be sensitised regarding these factors and reflect on them to be able to plan ways to overcome any difficulties. For example, political support to develop and implement a health policy can facilitate and even accelerate its formulation, while the absence of political influence can hinder the process (Smith and Katikireddi, 2013). The list below summarises various factors, which can be obstacles or facilitators for participation depending on the context and the type of the policy, mentioned in the literature:

- Political competition, power struggle, values and ethics, evidence, access to information, financial pressure, trust in the policymaking process, and public satisfaction with the implementation of policies (Smith and Katikireddi, 2013);
- Political will, commitment, and the availability of resources to implement policies (Matthews, Pulver and Ring, 2008);
- Level of interest, power, influence, relationships, and competition between stakeholders (Dieleman, Shaw and Zwankkon, 2001; Brugha and Varvasovszky, 2000; Brinkerhoff and Bossert, 2008);
- Supportive policy environment, governance and financing's independence, and strong associations with policymakers (Bennett, Corluka and Aikins, 2012).

The following factors are important to identify with the tool to build on facilitating factors and find ways to overcome the barriers to assessment in the policymaking process:

- Presence of a legal framework to enable participants' involvement in the decision-making process (Cornwall, Lucas and Pasteur, 2000);
- Institutional and technical capacity and leadership to bring participants together (Emerson, Nabatchi and Balogh, 2011).

- *Criteria for Effective/Meaningful Participation*

Given the obstacles to "effective" or "ideal" participation, numerous studies have attempted to identify key criteria to interpret the scope, level, and quality of participation in decision-making. In particular, Gaventa (2002) asserted that for effective and meaningful participation, consensus has to exist with regard to the orientation process (which considers the voices and positions of various stakeholders and does not merely allow free expression of opinion). Emerson, Nabatchi and Balogh (2011) added that well-informed participants, existence of standard operating procedures, by-laws, decision-related rules, a conflict resolution mechanism, as well as transparency in roles and responsibilities, shared commitment, motivation, and a shared set of values and goals are important to ensure the complete practise of effective participation.

Issues of representation (such as who is representing whom, how representatives are selected, among others) should also be considered in the context of participation (USAID, 2008). It is important to have the right balance between policymakers and the private sector, professionals and public/patients, and between men and women (Martin, Abelson and Singer, 2002).

The long list of the main characteristics and the concepts of participation constitute an ideal state of good governance. The tool will offer a practical assessment of these characteristics and will highlight them for policymakers, to drive them to consider these issues in a simplified manner.

At the same time, it is important to acknowledge the negative impact of participation as well, as reported in the literature and to highlight the difficulties involved in the application of GG practices by policymakers so that they can make informed decisions regarding their implementation.

- *Negative Impact of Participation*

The literature reports the following potential negatives impact of participation: a poorly designed process, time-consuming process, possible production of ambiguous data, broadly defined groups, need for financial resources, conflict of interests, power struggles, and representation imbalance, all which can affect the legitimacy of the representation and can result in the exercise of informal influence, silencing the stakeholder’s voice (Lavis, Posoda, Haines and Osei, 2004; Lopez et al., 2011).

In addition, it is claimed that enabling complete participation of all stakeholders in the policy process will reduce its efficiency of the process and can result in some participants

dominating the decision-making process (Bovaird, 2005). It has also been contended that the process might cause public dissatisfaction instead of increasing public trust (Irvin and Stansbury, 2004). In conclusion, negative impacts should be taken into account when planning participation so as to avoid these potential pitfalls.

3.1.3 Transparency

- *Definitions*

Transparency is defined as active disclosure of information regarding the formulation of decisions (Vian, 2008). A "free flow of information within the health sector as processes, institutions, and information should be directly accessible to those concerned with them, and enough information is provided to understand and monitor health matters" (Siddiqi et al., 2009,p.18). It also signifies "bringing previously opaque information or processes into public domain" (Joshi, 2013, p.s29).

- *Criteria for Transparency*

In order to have real "ideal" transparency in place, certain criteria need to be considered, and the quality of the data, the speed of making these available (NAO, 2012; Vian, 2008), and ease of access are important factors in effecting complete transparency (WHO, 2009). Additionally, there should be a mandate to disclose government information (Vian, 2008; WHO, 2009) and encourage cyber transparency (e-transparency) (Otenyo and Lind, 2004). Information regarding the way in which policies are formulated, even if they were based on evidence alone, other factors that may have affected policy formulation, as well as information regarding the progress of implementation and evaluation stages, among other things, should be available (Vian, 2008). This information should be disseminated to the public, different policy actors, participants in the policymaking process, and the media (Otenyo and Lind, 2004) to encourage participation as well as to promote accountability (Siddiqi et al., 2009). The availability of written documents on policies is a sign of transparency (Otenyo and Lind, 2004; Lopez et al., 2011).

- *Benefits of Transparency*

Arguments in favour of enhancing transparency include increasing public accountability by publishing data and information, increasing public trust as well as respect for government decisions and policies; furthermore, it is essential to citizens' compliance and acceptance of those decisions (NAO, 2012; WHO, 2009; Osborne, 2004; Licht, 2014). Disseminating good quality information is a critical element in effective management (NAO, 2012). Transparency can enhance the quality of decision-making during the policymaking process (Magraw and Amerasinghe, 2009) as it is considered a "golden tool in policymaking" (Licht, 2014, p.362). Additionally, transparency is an important component of any reform, and access to public sector information is a public right (NAO, 2012; Vian, 2008) as well as a salient requirement for donor agencies (Otenyo and Lind, 2004; Siddiqi and Jabbour, 2012).

- *Mechanisms of Transparency*

Mechanisms that are required to institutionalise the concept of transparency include existence of access to information law, e-government (the existence of an official website, availability of publications online, and online services), freedom of press (Relly and Sabharwal, 2009), availability of written standards on operating procedures, an effective decision-making process, and minutes of meetings, accompanied by appropriate communication strategies (Oxman, Leewin, Lavis, and Fretheim, 2009). Assessing the further for implementation of these mechanisms, for instance, it needs to be assessed whether written standards are adhered to or not, minutes of meetings are sufficiently clear to disclose information rather than hide it, and freedom of the press is utilised to aid effective decision-making rather than merely create a scandal, is beyond the scope of the tool. However, both policymakers and health authorities need to be aware of these mechanisms and the importance of their implementation in order to have a transparent system.

- *Strategies to Improve Transparency*

Institutional capacity and strategies are required to enhance ministries' transparency (Oxman et al., 2009). Different scholars have suggested different strategies to increase transparency, which include the publication of public service reports, release of government documents or decisions through websites, public databases, public meetings, and publication of reports on financial monitoring through different dissemination channels (Vian, 2008; Joshi, 2013; Osborne, 2004; Licht, 2014; WHO, 2009). What a policymaker may perceive as high level of transparency may be perceived as opacity by a stakeholder and inaccessibility by a citizen. Hence, a standardised list of "good practices" based on the literature and validated by experts is an absolute necessity. The proposed tool aims to help alert policymakers regarding practices and processes that might be valuable in improving transparency from a practical viewpoint. This list of characteristics of "real" transparency is a presumed *normative ideal* drawn from the literature. It is essential to acknowledge the complexities when one aims to achieve this state of "ideal" transparency (Meijer, 2013), sensitivity of introducing transparency into practices, and the difficulties in its actual assessment.

- *Negative Aspects of Transparency*

The implementation of full transparency also entails disadvantages similar to applying real participation. Increased transparency has been reported to be associated with increased administrative costs as the process of making relevant information easily accessible

necessities institutional as well as cultural changes (Magraw and Amerasinghe, 2009; Osborne, 2004). Making the information publicly available in a user friendly manner can be a time consuming process and can result in delays (Magraw et al., 2009). Moreover, transparency with regard to decision-making can also lead to increased disappointment with government decisions (Licht, 2014). Moreover, increasing access to information in an effort to improve transparency can cause overloading and confusion if the information released is complicated (Licht, 2014). Finally, transparency can easily impinge on confidential data and privacy (Meijer, 2013; Osborne, 2004).

3.1.4 Accountability

- *Definitions*

Accountability is defined "as the obligation of individuals or agencies to provide information about, or justifications for, their actions to actors along with imposition of sanctions for failure to comply or to engage in appropriate action" (Brinkerhoff, 2004, p.371). It concerns assuring that "those who are responsible for designing and implementing policies are held accountable for their performance and about having the right checks and balances put in place" (Dieleman et al., 2011, p.11).

- *Benefits of Accountability*

Accountability is needed in the health sector to control the misuse and abuse of resources and/or authority, ensure that resources are used effectively, ascertain that authority is exercised based on legal procedures, professional standards, and social values, as well as enhance management of health services through monitoring and evaluation (Brinkerhoff, 2004; Savedoff, 2011).

- *Types of Accountability*

Several types of accountability have been described in the literature: financial accountability, performance accountability, and political/democratic accountability (Brinkerhoff, 2004; Tuohy, 2003; Baez-Camargo and Jacobs, 2011). These accountability types were identified in relation to service delivery in the health sector; however, all of them might not be applicable to the health policymaking process. Thus, experts during the Delphi consultations needed to decide on the most relevant types that should be assessed.

Financial accountability refers to compliance with laws and regulations regarding financial issues (Brinkerhoff, 2004) and might be more applicable to policy implementation, unless it is related to resource allocation. Performance accountability includes performance

measurement and evaluation as well as service delivery improvement, and these should be outlined in the formulation plans of policies and when applied during implementing policies and strategies (Brinkerhoff, 2004; Baez-Camargo and Jacobs, 2011). Performance accountability also concerns enhancing citizen participation, regulations, resource allocation, transparency, responsiveness, and trust building (Brinkerhoff, 2004; Savedoff, 2011). Improving this type of accountability, through the creation and strengthening of incentives for health policymakers to respond to citizens' needs and demands, is essential (Kirigia and Kirigia, 2011; Brinkerhoff, 2004). This type of accountability is most applicable to policymaking process. Political/ democratic accountability pertains to focusing on the relationship between government and citizens, checking whether the former is acting in line with set standards, ethics, and principles of integrity (Brinkerhoff, 2004). However, this accountability type is beyond the scope of consideration for the health sector unless health professionals/health policymakers are elected for their positions in the government (Baez-Camargo and Jacobs, 2011).

In addition to the strong emphasis on public health sector accountability (with questions of private sector accountability addressed less directly), Murthy (2008) suggested that there is a gap in the enforcement of accountability, especially at the policymaking level, leading to negative consequences and the lack of "ideal/real" accountability. Further, he advises that accountability should be exercised prior to the formulation of a health policy as well as at different stages, before, during, and after the implementation of a programme (Murthy, 2008), through any of the accountability types mentioned above, if they are applicable. In conclusion, health authorities should be aware of the different kinds of accountability that can be applied at all levels of the health system.

- *Actors for Accountability*

All stakeholders involved in the health sector should be accountable to the public, and these include decision-makers in government, the private sector, civil society organisations, and institutional stakeholders. Further, it should also be observed that "accountability differs depending on the organisation and whether the decision is internal or external to an organisation" (Siddiqi et al., 2009, p.18). Furthermore, accountability is required at multiple levels; it can comprise internal reporting to a higher authority within the health sector (Murthy, 2008). For instance, within the state, parliaments can hold MoH officials accountable, in addition to other state audit and anticorruption agencies (Brinkerhoff and Bossert, 2008). It can also be external in relation to citizen groups or independent bodies (Murthy, 2008). Thus, it is essential to identify who is answerable to

whom and for what in the assessment of accountability; this will reflect whether internal and/or external accountability is being practised in the concerned sector (Baez-Camargo and Jacobs, 2011).

- *Components of Accountability*

In order to have complete and real accountability, three components or aspects of accountability are defined and should be in place: answerability/justification, sanctions, and enforcement (Brinkerhoff, 2004; Murthy; 2008; Joshi, 2013). Answerability itself covers two issues, monitoring (in which facts and figures/information regarding budget, descriptions of activities or outputs are given by the accountable actor to the overseeing one) and demanding justification for actions (Brinkerhoff, 2004; Baez et al., 2011). The presence of the three components together is essential to practise accountability in its totality (Joshi, 2013). Answerability can reveal illegal or inappropriate actions and behaviours that should be followed by sanctions, while enforcement concerns ensuring compliance with sanction decisions (Brinkerhoff, 2004; Murthy, 2008). This is because answerability without sanctions as well as sanctions that are not enforced will serve to weaken accountability (Murthy, 2008). Inconsistency between the sanctions that exist "on paper" and the capacity to enforce them can result in serious accountability problems (Brinkerhoff, 2004). Brinkerhoff (2004) highlighted the importance of identifying actors who are in a position to demand information and impose sanctions as well as those who are charged with supplying information and are subject to accountability within the health sector.

- *Types of Sanctions*

Brinkerhoff (2004) suggested sanctions that can be utilised to have accountability in place, including legal sanctions, regulatory sanctions, as well as licensing and accreditation standards, quality assurance guidelines, and compliance mechanisms and a code of conduct. Other softer sanctions include negative publicity, which can damage accountable actors' reputation or status (Vian, 2008). Healthcare providers are subject to professional codes of conduct (Ebrahim, 2003; Brinkerhoff, 2004; Vian, 2008); thus, it is essential for policymakers to know about the types of sanctions that can be applied in light of their mandate and authority.

Proper incentives and rewards for good performance are as important as sanctions; this aspect of accountability is commonly neglected (Brinkerhoff, 2004) and should thus be highlighted to policymakers (Ebrahim, 2003).

- *Mechanisms to Foster Accountability*

Accountability can be enhanced by an information system and the dissemination of information to the public and actors with oversight responsibility and capacity, encouraging watchdog organisations and non-governmental organisations (NGOs) can play this role, establishing whistle-blowing mechanisms, forming health boards or other civil organisations to demand explanation for results, providing performance incentives for good performance, setting clear procedural rules and using authority to enforce those rules, as well as creating citizen oversight that can take several forms (Saltman, 1997; Ebrahim, 2003; Vian, 2008; Brinkerhoff and Bossert, 2008; Murthy, 2008).

Policymakers should be aware of these mechanisms that can enhance accountability, their components as well as the types of accountability and sanctions. In order to have a complete picture, the potential negative effects of their use should also be considered.

- *Negative Aspects of Accountability*

Applying accountability requires time and monetary resources, and often, major institutional changes as well (Osborne, 2004). High levels of extensive checks and balances as part of exercising and practising accountability can also delay the policy process (Osborne, 2004). Moreover, it can result in power being accorded to certain stakeholders over others, which can thus discourage participation (Joshi, 2013). Workload has also been reported as another issue, whereby, as a result of the elaborate documentation and reporting required, public officials avoid accountability (Osborne, 2004).

3.1.5 Use of Information

- *Definitions*

"Information is essential for a good understanding of a health system, without which it is not possible to provide evidence for informed decisions that influence the behaviour of different interest groups that support, or at least do not conflict with, the strategic vision for health" (Siddiqi et al., 2009, p.18). It includes the processes of information generation, collection, analysis, as well as dissemination (Siddiqi et al., 2009; Kirigia et al., 2011). Information and intelligence also signify the use of research to inform policy (Siddiqi et al., 2009).

The focus with regard to this principle is twofold: the willingness and ability to generate evidence-based, research-generated, up-to-date, and locally relevant information (Orem et

al., 2012) as well as on using this information/evidence to inform policymaking and information dissemination (Siddiqi et al, 2009).

- *Benefits of Information Generation and Use*

The generation and use of information is essential in the health sector. GG requires useful "good information" and appropriate health intelligence (Policy Innovation for Health (PIH), Ch. 2). Not all organisations acknowledge the use of information as a principle of GG (as indicted by the list in chapter one). However, most individuals working in the health sector acknowledge its importance as a GG practice, essential in policymaking in particular (WHO, 2000; USAID, 2008; Siddiqi et al., 2009) as it is a sector specific aspect (WHO, 2009). Moreover, research can play a role at almost all levels of the policy process: agenda setting, formulation, implementation, as well as evaluation (Hanney, Gonzalez, Buxton and Kogan, 2003). In policy formulation, research findings can be utilised to create briefs to inform arguments, demonstrate the best way to implement policy, inform decisions, and provide justification for the policy to generate the required financial resources, political commitment, and/or to gain public support (Hanney et al., 2003).

Public policymakers face several challenges in finding solutions to health problems in the optimum way possible within a complex health system and the best methods to changes in health systems (Oxman, 2009). Research can help answer these questions and find practical solutions that are cost-effective (Lavis et al., 2004). Using high-quality and locally applicable research can significantly contribute to the policymaking process (Lavis et al., 2004). It is the responsibility of the MoHs to encourage, commit, and link evidence to policymaking (Oxman, 2009; WHO, 2010).

Informing policy with research can facilitate the production of better policies than would be possible otherwise (Hallsworth and Rutter, 2011). Moreover, research often enables policies that have a technically well-informed foundation (Hanney et al., 2003). The generation and use of evidence in health policymaking plays an important role in guiding investment decisions (given the budget constraints) towards improving service delivery and consequently health outcomes (Orem et al., 2012). Accordingly, new policies must be evidence-based, founded on data, statistics, and other indicators (PIH, Ch. 2). In reality, research evidence competes with other factors, such as financial resource availability and legal issues, with values, public opinion, influence of the private sector, among others), visibility, as well as other interests (Lavis, 2006). These need to be identified in order to improve the uptake of evidence into policies.

- *How Information Can Be Used in Policymaking*

There are three primary ways in which information can be utilised in policymaking: data and findings, ideas and criticism, or briefs and arguments for action, with their application in policymaking being instrumental, conceptual, or symbolic (Hanney et al., 2003). Instrumental application implies employing research findings as they are in policy formulation, while the conceptual aspect refers to utilising them as a way of informing or guiding, a symbolic means, using these findings to support a position already taken, for example, continue with existing policies (Hanney et al., 2003).

- *Factors that Affect the Use of Information*

This rather straightforward description of the use of information should not, however, overlook the practical complexities of the way in which knowledge/information can and is exploited in policymaking (Oxman et al., 2009). These complexities are the result of several obstacles to the use of information in policymaking as there are other factors that can increase information use (Hanney et al., 2003). According to the literature, there are four groups of factors that influence evidence's uptake by decision makers: external, context, type of evidence, and stakeholders (Orem et al., 2012), which are described below:

a. **External influence:** This includes encouragement and influence of donors and international agencies by supporting national and regional efforts to undertake research that can inform policies and assessing their local applicability (Lavis et al., 2004) and the existence of global evidence regarding their use (WHO, 2010).
b. **Context:** This includes consistency with the governing party's political views (Lavis et al., 2004), politics, economic resources, incentives for researchers and policymakers, opinions of the mass media and public, demand for an evidence base, ways of knowledge transfer/translation, knowledge brokers, publicly funded research, government encouragement and commitment to linking evidence with policy (WHO, 2010), as well as institutional capacity for research analysis and policy formulation along with the urgency to have a policy in place (Orem et al., 2012).
c. **Type of evidence:** This includes technical content and quality (reliability, timeliness, specificity, comprehensiveness), practicality, issue complexity, the way in which results are communicated (summaries, through media), feasibility of applying the evidence-based recommendations, administrative capacities, financial situation, their acceptability to key health system stakeholders (civil society groups, patient groups, professional associations, NGOs, private business, donors and international agencies), and national significance (Lavis et al., 2004; Hanney et al., 2003).

d. **Stakeholders:** These include the relationships between researchers and policymakers, acceptability to key stakeholders, public engagement, power of pressure groups, successful advocacy, partnership, synergy and coordination with academia/research centres (Lavis et al., 2004; Hanney et al., 2003; Davis et al., 1996; Orem et al., 2012; Siddiqi et al., 2012). It is extremely important to explore the relationship between policy/policymakers and research/researchers in real life. It is considered as one involving exchange, in which, policymakers usually act as receptors/recipients of research (Hanney et al., 2003).

Scientists can benefit from publicly funded research (Choi, Pang, Lin, Puska, Sherman, Goddaed, Ackland, Sainsbury, Stachenko, Morrison and Clottey, 2005). Their goal is to advance science and their major output is research papers (to contribute to the body of knowledge), while policymakers' goal is to secure practical support to implement policies (Choi et al., 2005). Since there is a gap between data production and data use, there is a need for a partnership between government policy bodies and experienced academic/research organisations(Choi et al., 2005).

The most common facilitating factors for the transfer of evidence to policymakers include personal contacts, time-based relevance, the inclusion of summaries with policy recommendations, good quality research, community pressure/demand for research, and media reports (Travis et al., 2002; Choi et al., 2005; Lewis and Pettersson, 2009; Siddiqqi et al., 2009; Jansen et al., 2010). While barriers to the use of evidence are lack of personal contact, delay in releasing research findings, lack of trust, limited budgets, poor quality of research, and political instability (Choi et al., 2005; Veillard et al., 2011; Savedoff, 2011), to overcome some of these barriers and to facilitate the use of information and evidence by policymakers, it is essential to invest in institutional strengthening. This can be accomplished through continuing education programmes for public policymakers to promote the value of evidence use and increase their capacity to access, adapt, and apply research evidence (Lavis, 2006).

- *Negative Aspects of Information Use*

The collection, analysis, generation, and dissemination of information entails financial costs and also requires professional expertise that might not be available all the time for public policymaking (Bao, Wang, Larsen and Morgan, 2012). Additionally, the production of quality information is a time-consuming process (Jansen et al., 2010).

3.1.6 Responsiveness

Responsiveness is classified as both a principle of GG and its outcome. Unlike other outcomes such as equity, efficiency, and effectiveness that might be the result of other factors that work together in addition to GG, responsiveness forms a direct outcome. The WHO identified responsiveness as one of three intrinsic goals of a health system's performance, with the other two being health services and fair financing (Darby et al., 2000). Furthermore, according to the WHO, responsiveness addresses the people's legitimate expectations, which forms the core of health systems' stewardship function (WHO, 2000). It is a fundamental aspect because it is related to basic human rights. Health systems' responsiveness can be enhanced without large investments as it does not necessarily require new legislation for its authorisation (Darby et al., 2000). Finally, responsiveness can be improved at a considerably faster pace than health, that is, it can improve people's well-being, irrespective of improvement in their health (Gostin, Hadge and Valentine, 2003). Thus, by ensuring that people are treated in ways that correspond to their needs, they can be empowered to lead healthier lives (Gostin, Hadge and Valentine, 2003).

Despite the importance of responsiveness, it has not been adequately developed as a concept, thus making its evaluation difficult. I have labelled it as an "orphan principle" as all papers identified in the literature on responsiveness deal with it in terms the service delivery level (Darby et al., 2000; Gostin et al., 2003). That is, I was not able to find research relevant to responsiveness at the health policymaking process level. Thus, under this principle, I will present the findings from the literature in relation to health service delivery and make the link for the health policymaking process.

- *Definitions*

Responsiveness is defined as "how well health system meets the legitimate expectations of population for non-health enhancing aspects/dimensions of their interaction with the health system" (Darby et al., 2000). Siddiqi et al. (2009, p.18) explained it as "institutions and processes should try to serve all stakeholders to ensure that the policies and programs are responsive to the health and non-health needs of its users". Governments/MoHs are obliged to listen to the needs of their citizens, act on their concerns, and respond to their expectations in developing policies (Siddiqi et al., 2009; Ura and Ellis, 2008). Thus, responsiveness is an important aspect of governance that requires to be assessed in order to be improved.

To develop the tool, I start from the most advanced/elaborated conceptualisations of responsiveness in the health sector proposed by Darby et al. (2000) and Gostin et al. (2003) in collaboration with the WHO. They defined seven domains for health responsiveness at the service delivery level: respect for dignity of persons, confidentiality, autonomy to participate in health-related decisions, prompt attention, access to basic amenities of adequate quality of care, choice of healthcare provider, and communication (Darby et al., 2000; Gostin et al., 2003).

The responsiveness domains were further elaborated and defined based on the work of Gostin et al. (2003), and they were associated with health policymaking as follows:

- **Dignity:** All individuals should be treated with respect, with no discrimination based on race, sex, religion, ethnicity, and other aspects (Gostin et al., 2003), that is, any health policy should be based on respect for the dignity of patients/public.
- **Autonomy to participate in health-related decisions and to select the healthcare provider:** This concerns the freedom to seek, receive, and impart information, as well as the right to free, meaningful, and effective participation in decisions that affect one's life (Gostin et al., 2003). In addition, each individual has the right to select the healthcare provider they want (Gostin et al., 2003). Therefore, health policies should be based on allowing patients and the public a say in the formulation of such policies as well as empowering them to make decisions related to their health.
- **Privacy and confidentiality:** Respect for persons in the health care context includes the duty to maintain a patient's medical information as private and confidential (Gostin el al., 2003). Linking this domain to the formulation of health policies related to providing health services, respecting patients' and public's confidentiality when it comes to their medical information should be a part of every health policy.
- **Prompt attention:** This refers to offering timely service to avoid potential anxiety and inconvenience due to delays in giving attention or care (Gostin et al., 2003). Accordingly, health policies should be formulated with the obligation to ensure that the health system is responsive in a timely manner and services are accessible and provided without any delays.
- **Access to adequate quality of basic amenities:** This is connected with al individuals' right to an adequate standard quality health service (Gostin et al., 2003). Thus, any health policy should include the specific entitlement to the health services to be provided.

- **Communication:** Patients should be given the right to seek, receive, and impart information related to their health (Gostin et al., 2003).

Adhering to all these elements of responsiveness in the formulation of health policies will make it possible to hold policymakers and other actors accountable (Gostin et al., 2003; Powell, 2004). In order to use responsiveness as a principle of GG at the health policymaking level, the tool's application will highlight these elements/domains of responsiveness and the fact that they should be a constituent of any health policy to be developed.

It is important for policymakers to understand people's perception regarding the responsiveness of a health system to their needs and assess factors that contribute to this perception in order to address them appropriately (Siddiqi et al., 2009). In most cases, this is not done, as the population's health needs are usually determined by health professionals with little involvement of the public (Gostin et al., 2003).

Factors that influence a government's responsiveness to the needs of its people include the following: "National mood", nature of the policy issue, the urgency of the issue and the degree of seriousness/level of priority, costs of being responsive, involvement in changing an old established policy, media coverage, informed public, informed policymakers, social movements and pressure, availability of "open window of opportunity", influence of elites, contradictory public opinion, timing, government's commitment towards responsiveness, and inequality in representation (Manza, 2002; Powell, 2004; Ura, 2008; Wlezien, 2009).

- *Mechanisms to Enhance Responsiveness*

These include institutional changes to enable the collection of public preferences, responding to media reports, enabling participation along with public polls, and surveys (Gaventa, 2002). All the positive characteristics and the concepts identified for the five principles discussed above represent the "ideal" situation in the application of GG principles. However, applying these may prove to be a burden to the efficiency of the policymaking process (Bovaird, 2005). That is, it is not possible to achieve all these characteristics/good practices at the same time (Bovaird, 2005), and thus, it is necessary to be realistic about what can and/or must be included for improvements (Fryatt et al., 2017). The disadvantages of GG principles that can obstruct or delay the policy formulation process can be minimised, if planning is done carefully (Irvin and Stansbury, 2004; Magraw et al., 2009). The advantages of GG practices and their contribution to the quality of health policymaking process and their possible influence on the health system performance outweighs all the potential disadvantages.

3.1.7 The Interrelationships Between the Principles

The literature suggests there is an interrelationship between the various GG principles, and in some cases, there is also an overlap (Papadopoulos et al., 2007; Labonte, 2010; Mutale et al., 2013). However, no empirical evidence is available regarding this; there are only theories regarding the potential relationships. Effective participation can be enhanced by increasing access to information, whereby participants will be empowered by access to relevant information (Mutale et al., 2013). Moreover, participation will lead to increased visibility and transparency of the procedures followed during the policymaking process (Papadopoulos et al., 2007), and the opposite is also true; conversely, the lack of transparency may discourage participation (Labonte, 2010). Civil society's participation can play a vital role in establishing research priorities and the data that should be generated and the way in which it will be presented (Choi et al., 2005). In addition, enabling the participation of all stakeholders will allow the public to voice their needs and thus encourage the government to be responsive to those needs (Darby et al., 2000).

Transparency is considered a tool to enhance accountability (Otenyo et al., 2004), whereby providing information to the public will increase its demand (Joshi, 2013). In addition, it is a pre-requisite for participation as it can encourage stakeholders to play an active role (Magraw and Amerasinghe, 2009). In general, the use of information (including generation and dissemination) is essential for real transparency (Lavis et al., 2004). Transparency regarding the process and the decisions taken during policymaking through proper communication channels will allow the public to know whether the government is responsive to their needs (Gostin et al., 2003).

Despite theories that signify the presence of interrelationships between GG principles, it is important that they are assessed separately within the tool and the characteristics are labelled under the relevant principle. This will help expand the understanding of the meanings of each of the principles and the way in which they constitute GG practices.

The subsequent phases of the research (the Delphi and the pilot), with the tool devised, helped remove any overlaps, to the extent possible, among the principles.

This research does not explore these relationships in any way but acknowledges their presence.

3.1.8 Development of Checklists

In order to finalise the conceptualisation step, I had to group the characteristics that needed to be covered under each principle. Accordingly, a checklist was developed that summarised what the tool should cover in terms of the characteristics of the five governance principles. This checklist guided the tool's operationalisation. Devellis (2003) stated that "the boundaries of a phenomenon must be recognised so the content of the scale does not inadvertently drift into unintended domains". Hence, I employed the components/characteristics of each governance principle to define that principle and used it as a guideline/indicator for "good practices" that needs to be followed in order to achieve GG (Andrews, 2008).

The level of specificity or generality of the tool requires to be determined before the tool is developed (Foa and Tanner, 2011; Devellis, 2003). Thus, this research attempted to explore into details regarding governance principles in order to capture the maximum amount of information as to the way in which these governance principles can be enacted in practice. Table three offers a summary of the primary main characterises of the five principles identified in the literature review. These concepts were added if they appeared several times in the literature, if convincing arguments regarding their importance were presented, and based on my own judgment concerning their relevance to the health policy process.

Table 3: Checklists of the Major Characteristics of HSG Principles

Participation	Accountability	Transparency	Information Use and Generation	Responsiveness
Types of Participants • State actors • Health service providers • Public • Others	Components of Accountability • Answerability • Sanctions • Rewards • Enforcement	Criteria for Transparency • Quality of data • Speed of publishing data • Ease of access	Generation, Publication, and Dissemination of Useful Information	Elements of Responsiveness • Respect for dignity • Autonomy to participate in decisions • Confidentiality • Prompt attention • Adequate basic health services • Communication
Representativeness • Organisations • Themselves Benefits of Participation • Ownership • Human right • Knowledgeable people • Democracy	Types of Accountability • Financial Accountability • Performance Accountability • Political Accountability • Internal against Eternal • Formal against Informal	Mechanisms of Transparency • Law to disclose • E-Transparency • Freedom of press • Written SOPs and Minutes of Meetings • Documentation of policies	Types of Information • Evidence-based • Financial resources • Laws • Values	Benefits of Responsiveness • Human right • Improve wellbeing • Goal of health system performance • Direct outcome of governance
Negative Impact of Participation • Time consuming • Conflict of interest • Costly	Benefits of Accountability • Control misuse and abuse • Efficient use of resources • Appropriate procedures • Improved service delivery	Benefits of Transparency • Increase public accountability • Increase public trust • Effective management • Reform component • Empower citizens • Prerequisite for donors	Factors Affecting Use of Information: • External factors • Context • Type of evidence • Stakeholders and their relationship	Factors Influencing responsiveness: • "National Mood" and timing • Nature of the policy issue • Level of priority • media coverage • Social movements and pressure • availability of "open window of opportunity" • Government commitment to be responsive to the needs of the population
Barriers/Facilitators of Participation • Political will • Power struggle • Financial resources • Context	Actors in Accountability • Policymakers • Private Sector • Civil societies • Public	Strategies to Enhance Transparency • Publishing public service reports • Financial monitoring • Release of government decisions	Benefits for Generation and Use of Information	
Criteria for Effective Participation • Consensus orientation • Transparency • Available information • SOPs	Mechanisms to Foster Accountability • Information System • Dissemination of information • Watchdog organisations • Whistleblowing mechanisms			

Mechanisms to Enhance Participation • Public inquires • Policy dialogue • Citizen juries • Assessments • Roundtables • Contracts • Committees	Types of Sanctions • Legal sanctions • Regulatory Sanctions • Negative publicity • Soft sanctions			

The checklists offer indications as to what the tool should cover under each of the five principles. In order to assess whether there is an "effective" participatory policy process, it is necessary to identify all kinds of participants involved in the policymaking process, the benefits and negative impact of participation, barriers as well as facilitating factors, mechanisms and methods applied to enhance participation, along with the criteria for effective participation and consensus process, as well as representation. For enhanced accountability, the presence of its various components including procedures, methods, types, and levels of accountability, needs to be assessed. Moreover, the actors involved require to be identified along with the benefits of accountability at the policymaking level. For a transparent policymaking process, the relevant criteria, namely benefits, methods, and levels also need to be considered. With regard to the use of information, the ability of MOHs to generate information as well as the use of information in policymaking requires to be assessed. Consequently, it is important to examine the generation, publication, and dissemination of health-related information, types of information collected and used, criteria and factors involved in the use of information in policy, and benefits of generation and use of information at the policy level. For a health policy to be responsive to the needs of the population, the various elements of responsiveness, its benefits, and factors need to be considered in order to effectively enhance it.

Before the development of a framework for the tool, it was essential to decide what this framework should include. It was recognised that the framework required to reflect the scope of the tool, i. e., assess the five principles at the health policymaking level. After unpacking the principles, a decision had to be made regarding the way in which the policymaking process could be represented in the framework.

3.2 Development of a Conceptual Framework

A conceptual framework/model of the selected GG principles and their characteristics is required to reflect reality and offer clarity before any attempt can be made to assess HSG (Andrews, 2008; Emerson, Nabatchi and Bologh, 2011). According to Andrews (2008, p.380), "Models are stories by which we connect certain elements and characteristics with certain realities and often take shape of structural designs for others to emulate." The developed framework was utilised as a roadmap to develop the tool that would enable policymakers and stakeholders to assess health governance in practice (Charles and de Maio, 1993; Emerson, Nabatchi and Bologh, 2011).

In the proposed framework (Figure 2), the first diagram organises the five key principles of governance (participation, transparency, accountability, use of information, and responsiveness) into multi-graphics and suggests a link/interrelationship between them; however, it offers no explicit proposition as to how the interaction is realised. The arrows between the five principles point in both directions, and a box next to each principle summarises its main characteristics. The second diagram depicts the policy cycle stages (agenda setting, policy formulation, policy implementation, evaluation, and monitoring). The two diagrams represent "moving wheels", in which all the governance principles interact with all the policy stages. However, the framework will not illustrate the way in which the principles interact with the different policy stages nor how they impact each stage. Although the framework presents all the policy cycle stages, this research will concentrate only on assessing the five principles for policy formulation. It is suggested that the interaction of the governance principles and the policy stages is also affected by the contextual factors that affect the health sector in particular and the country in general.

The suggested framework can be utilised as a broad map to facilitate understanding, development, and evaluation of theories related to the enhancement of the health policymaking process through the application of GG principles in practice (Charles and de Maio, 1993; Emerson, Nabatchi and Bologh, 2011).

I understand that the five principles are interconnected and act as precursors to each other, thus enhancing each other. Furthermore, I also understand that not all these principles contribute equally to the quality of governance; however, exploring these issues is beyond the scope of this research. Thus, further research is required to test and explain the possible causal relationships between the principles on the one hand and the magnitude of their effect on the governance of the policymaking process on the other hand.

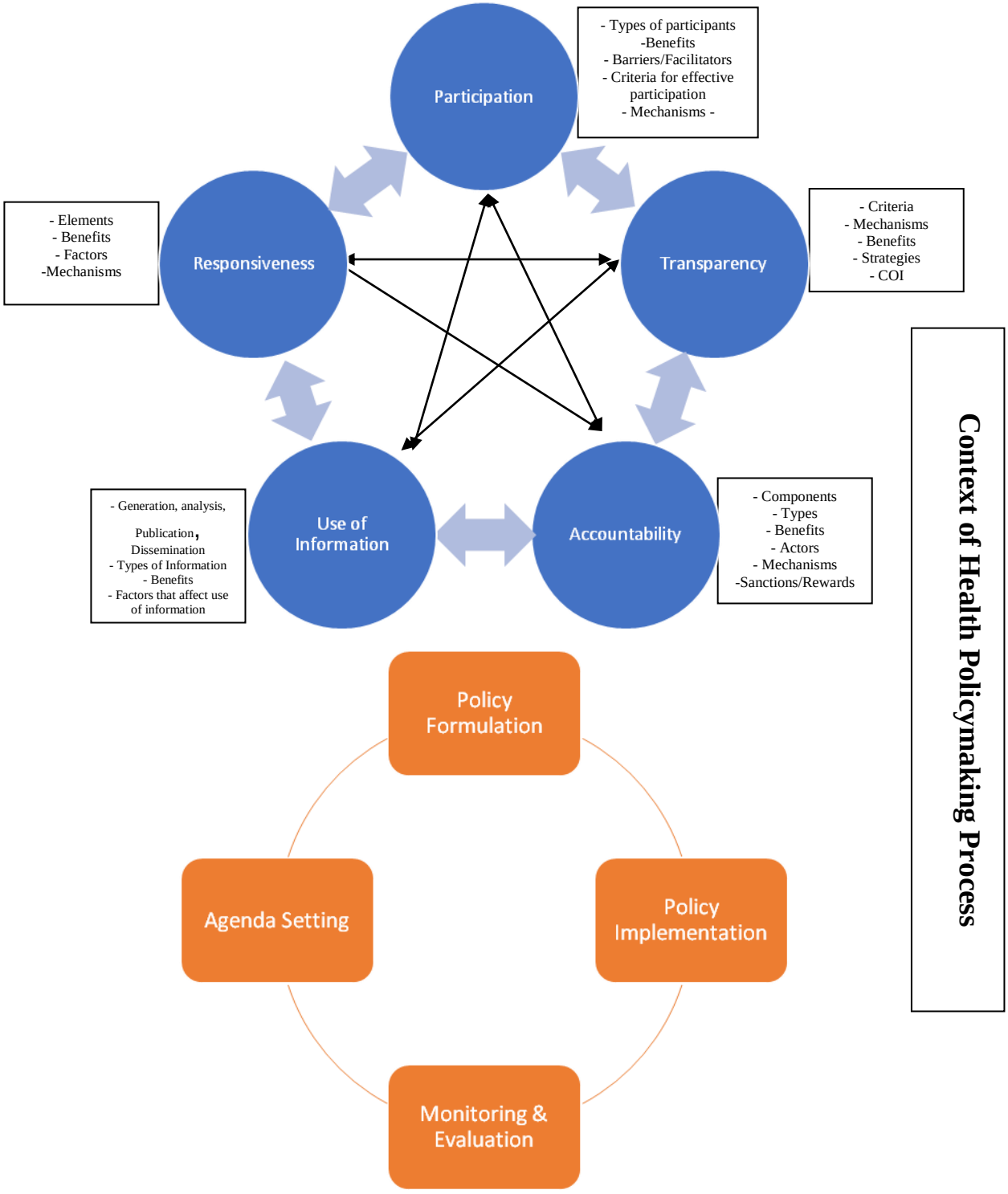

Figure 2: Framework for Assessing Key Governance Principles at the Health Policymaking Level

3.3 Operationalisation of the Principles of HSG

Considering the scope of the research, the tool will focus on assessing processes and not measures of output/performance (Fukuyama, 2013; Rotberg, 2014). Operationalisation was defined in Chapter Two as a process that is commonly employed in the social sciences (Tucker, 2012) along with topics that are considered complex and are constantly discussed, with consensus over their meaning being elusive, as is the case with health governance (Fukuyama, 2013). The operationalisation of concepts we want to assess requires a strong theoretical foundation (Devellis, 2003) to facilitate the process (Covell and Sidani, 2012).

In simple terms, operationalisation entails the translation of concepts into measures (in this case, questions) (Saris and Gallhofer, 2004), and each concept can be translated into one or more relevant questions (Buckingham and Saunders, 2004, Ch.3). These questions concerning the mechanisms followed to adhere to principles of GG are addressed to policy stakeholders. Once the theoretical definitions and descriptions of the various principles and their characteristics have been identified (the conceptualisation phase explained above), the subsequent logical step is to transform these into useful descriptions and applications (operationalisation) (Tucker, 2012) in order to enable their assessment in a practical and meaningful manner, and this can be through the development of a tool comprising several indices.

3.3.1 Development of Assessment Tool/Indices

Since a concrete definition of governance is associated with several principles , it should be accessed through multiple measures or composite indices (Carmines and Woods, 2004b).

An index refers to "a composite of several items assuming that all reflect on the underlying construct" (Carmines and Woods, 2004b, p.486). A composite index is widely employed by international organisations and the academia (Foa and Tanner, 2011; NCAER, paper no. 83) for assessing broad social science concepts such as governance, human development, and social development, which has been found to be an acceptable way of assessing governmental agencies (OECD, 2005).

The use of an index offers the advantage of summarising characteristics/concepts associated with each of the GG principles in a simple manner (Fao and Tanner, 2011); it also serves as a checklist of good practices. However, their inability to confirm whether

progress observed is exclusively due to change in governance practices (WHO, 2010) rather external factors is a limitation that might affect the assessment's usefulness (Veillard et al., 2011; Rotberg, 2014). Hence, external factors that might affect the governance process require to be taken into consideration in any attempt to assess health governance. A separate index for each of the five principles will not allow the evaluation of the overlapping nature of the relationship between the principles (Nyhan and Woolcock, 2012). However, this is beyond the scope of this tool. One particular challenge presented by the use of an index is its conceptualisation and operationalisation, for if this is poorly pursued, a poorly developed index will be formed (Develis, 2003). In other words, if some major concepts related to the governance principles are excluded or if the individual questions that constitute the index are ill-developed, the assessment of the principles will remain incomplete (Develis, 2003). In conclusion, the conceptualisation of governance principles should be sufficiently inclusive of all the relevant concepts, and operationalisation of the composite tool should be undertaken carefully so as to completely capture what it aims to assess (Diamantopoulos and Winklhofer, 2001).

As mentioned above, as a part of the operationalisation step, an index was developed for each of the five governance principles to be assessed. Each index comprised a list of questions concerning the main characteristics of these principles.

Developing the proposed tool was accomplished by following a methodology adapted by Develis' (2003) work, which included a five-step process as indicated below:

- *a. Item Generation and Selection of Items to Be Assessed*

All concepts in the checklists above were included in the tool, and then, each concept within the checklists was translated into one or more questions (Buckingham and Saunders, 2004, Ch.3). Special attention was given to face validity and the unidimensionality of each of the questions formulated (Diamantopoulos and Winklhofer, 2001; Develis, 2003). The generation of three to four times questions more than the number intended is considered an advantage at this stage of the index development process as it will ensure internal consistency (Devellis, 2003) as well as minimise measurement error (Buckingham and Saunders, Ch.3). This resulted in an extensive list of questions for the Delphi consultations and the pilot testing. In addition to the questions that were generated based on the checklists, some others were adopted from existing assessments on health governance and used verbatim or were modified as identified through the literature review (see Annex 1. Mapping of Existing Questions from Other Assessment Tools).

- *b. Determine the Types of Questions to Be Developed*

Applying a combination of data collection methods is a recommended practice to operationalise the characteristics of the five principles in a comprehensive manner as much as possible (WHO, 2009). This can provide evidence as well as perceptions regarding ways to achieve improved governance, consistent with the public sector integrity assessment tool of the OECD (2005) and Good Governance in Medicine, an assessment tool for the public pharmaceutical sector developed by WHO (2009).

For each of the five principles, a composite index (30–38 questions) based on the main characteristics of each principle was developed. Each index contained questions assessing whether countries possessed the required processes or structures in terms of policies, laws, and strategies to ensure GG at the policymaking level (WHO, 2010) and whether these were enforced. The absence of such practices would reveal the gaps in the way in which MoHs or health authorities govern the policymaking process.

Each index comprised "evidence-based" questions (EBQ) and "perception-based" questions (PBQ). Thus, for each principle, two lists of questions were developed. The EBQ demanded either a binary answer (Yes/No) or a list of sub-criteria to select answers from (these sub-criteria will serve as checklists of good practices). The PBQ were set in the form of open-ended questions.

EBQs would be used to assess governance across time within countries, and these questions would be supported by documented evidence (thus the label evidence-based). The evidence for these questions would be collected through desk-review and an analysis of available information found in relevant documents,

while the PBQs were formulated in a way so as to yield more in-depth information, taking into account the specific context of a given country. The assessment is based on the evaluation of the role of MoHs in practising the principles of governance in the health policymaking process and the external factors that affect this. Specifically, these questions address various stakeholders' perception, who are involved or affected by the health policy (Foa and Tanner, 2011). Assessments based on perception have been widely employed by a number of international organisations (WHO, 2009; Siddiqi et al., 2009; USAID, 2012; LMG, 2012). The data for these kinds of questions will be collected through a questionnaire administered during face-to-face interviews with relevant KI from the health sector.

- *c. The Process of Writing Questions*

This is considered the most difficult step in the process of index development. The questions should cover relevant topics without any ambiguity (Diamantopoulos and Winklhofer, 2001, p.272; Devellis, 2003; p.69). This is because ambiguity may cause people to respond differently to the same question even if they have the same opinion on a particular matter (Fukumaya, 2013). In addition, some people tend to apply the same concepts but imply different things when referring to them (Soukakou and Sylva, 2012). In order to minimise any possible bias due to the question design, complex, double-barrelled, technical, as well as uncommon and vague words were avoided (Choi et al., 2005).

See Box 1 below for examples on the operationalisation of the concepts across the five principles and possible sources of data.

Box 1. Examples of Questions Developed Across the Five Principles

Principle	Characteristics	Example of Questions	Data Source
Participation	Legal framework for participation to be involved in decision making	**Evidence-Based Question** Is there a legal basis/requirement (law/regulation/policy) to include various stakeholders in the health policymaking process? If yes, please specify what it is.	Relevant legal documents: law, decree, among others Verified by KI interviews
	Institutional, technical capacity and leadership to facilitate participation process	**Perception-Based Question** How do you view the role of MoH/health authorities/national programmes in encouraging stakeholder participation in policy formulation and in the development of X Policy specifically? Does the MoH/health authority/national programme have the institutional capacity and resources required to facilitate the participation process, in terms of leadership, planning, needed information, institutional arrangements, database of key stakeholders?	KI Interviews
Transparency	Decisions related to priority setting and financial allocation should be made public	**Evidence-Based Question** Are decisions related to priority setting regarding X Policy made public? If yes, how?	Relevant published decisions, verified through KI interviews
	Institutional capacities and means to enhance it	**Perception-Based Question** How can the MoH/health authority/national programme increase its transparency in the policymaking process? Does the MoH/health authority/national programme have the needed capacity/means to achieve better transparency?	KI interviews
Accountability	Types of accountability	**Evidence-Based Question** What are the types of accountability mechanisms/types used by the MoH/health authority/national programme and various institutions/organisations involved in policy towards their representatives? Ethical, professional/performance, legal, financial, others	Relevant documents verified by KI interviews
	Inform stakeholders in advance that they will be held accountable	**Perception-Based Question** What is the best way to make various stakeholders accountable for their role in policymaking? How can it be ensured that they know they will be held accountable prior to their involvement?	KI interviews

Box 1. ***(Contd.)***

Principle	Characteristics	Example of Questions	Data Source
Use of Information	Use of information includes generation, publication, and dissemination of useful information	**Evidence-Based Question** Is the MoH/health authority/national programme directly involved in the following in relation to policymaking: information generation, dissemination of health information, publication and/or knowledge translation into policy?	Relevant publications verified by KI interviews
	Government encouragement and commitment to linking evidence to policy	**Perception-Based Question** How committed is the MoH/Health Authority/National Programme leadership to using evidence-based (scientific evidence) and other types of information in the policymaking process? What is the evidence for this commitment? Has it been documented?	KI interviews
Responsiveness	Elements of responsiveness include access to adequate quality of basic health services, among other things	**Evidence-Based Question** Does X Policy include an objective/goal that MoH/health authority/national program will ensure access to adequate quality of care services for all the population/patients, including disadvantaged/vulnerable groups covered under the policy?	Relevant policy document(s) verified by KI interviews
	Mechanisms to improve responsiveness include institutional change and assessing public preferences, among other things	**Perception-Based Question:** How do you view the MoH/health authority/national programme institutional capacity to collect/gather public needs/preferences that are to be incorporated into policymaking process? What mechanisms can be employed to improve policy responsiveness to the population's needs?	KI interviews

- *d. Questions Weighting*

Assigning significance to various items or principles based on their contribution to the quality of governance is beyond the scope of this study. As mentioned earlier, it is not an aim of this research to determine the prominence of the characteristics of governance principles. Assiging weight would require additional understanding of the various characteristics and the way in which they affect the quality of GG principles in real settings (Luiz, Pereira and Oliveira, 2012).

For this research, questions within the composite indices have been given equal weights. This is considered acceptable (NCAER, paper no. 83) since the focus is on identifying gaps and institutional weaknesses, rather than on coming up with a number or a score. The results of this tool is not to produce a score that does not consider contextual factors but rather to provide policymakers with usable data to improve the policymaking process accordingly (Kettl, 2016). Thus, this research does not involve assigning weights to the

different principles or their components based on their contribution to the quality of health governance, an issue that needs to be addressed in future research.

An important question with regard to the development of the tool is whether to assign scores for EBQs. This was addressed during a consultation meeting that took place for further evaluation of the tool (see Chapter Four, Consultation Meeting-Analysis Feedback), and it was decided that graphic-like summaries of the findings would be used so as to make the data useful for policymakers (Kettl, 2016), yet be able to track changes/progress overtime.

- *e. Decide on the Size of Individual Indices*

The number of questions in each index should not be short as that would compromise the index' comprehensiveness, and they should not be very long either, which would make the collection and analysis of the data burdened tasks (Develis, 2003). Expert opinions were required to identify the most important questions in order to include the assessment of governance processes, having consulted the literature and to seek their views as to whether any salient ones had been omitted. As mentioned earlier, this was done using the Delphi method. Consensus regarding the most important concepts of governance principles to be covered by the tool was an essential step; as discussed earlier, conceptual problems are still an issue in the assessment of health governance as it is the case with other fields, such as political science (Soukakou and Sylva, 2012; Fukuyama, 2013).

The initial number of questions developed to cover the five principles was 140 EBQ and 92 PBQ. All the EBQ for the five principles were put in Section A of the tool, While all the PBQ for the five principles were put in Section B of the tool. This resulted in the creation of a long tool, which presented a practical obstacle (as will be discussed in the subsequent chapters). However, the aim was to minimise measurement error as much as possible by covering all the concepts identified (Tucker, 2012).

3.4 Reflecting on Conceptualization and Operationalisation

All the characteristics attached to each of the five principles identified from the literature review were included based on their importance and my personal interpretation of their relevance in relation to the scope of the tool. The characteristics were subsequently categorized into meaningful components that describe "ideal" GG practices that should be applied by MoHs and/or health authorities at the policymaking level. All the identified

concepts were operationalised into the first draft of the tool to enable their assessment in a practical manner.

Therefore, the tool represents a first attempt (to the extent of my knowledge) to offer a detailed assessment of the five governance principles at the health policymaking level. Thus, a major contribution of this first phase of this research was to provide an in-depth understanding of the way in which the five principles could be assessed in a practical manner.

As mentioned earlier, there is a need to develop a practical tool based on academic standards and methods; the conceptualisation and the operationalisation were the first steps towards fulfilling this need.

Due to the lack of agreement concerning the implication of these principles in practical terms, a multi-perspective input from governance experts (through Delphi consultations) as well as policymakers (through face-to-face consultation meetings) and their consensus was required to complement the findings of the literature review. This is important to minimise any bias caused by the personal interpretation of the literature.

In conclusion, the first phase of this research included conceptualisation in the form of a literature review on health governance and its principles, summarising the key findings in a coherent and logical manner, preparation of checklists that included the main concepts and the development of a conceptual framework. It also involved the operationalisation of these main concepts of governance principles into the tool constituted by composite indices with both EBQ and PBQ. The outcome of this phase was the development of the first draft of the tool organised around five principles and two types of data generation that needs to be further refined, which was validated by Delphi experts and a group of policymakers; this has been discussed in the following chapter.

Chapter Four

Refining the Assessment Tool Using the Delphi Method and Consultation With Policymakers

This chapter includes a description of the second phase of this research. It offers an explanation of the way in which the tool was refined, validated, and further developed through Delphi method consultations with governance experts and of the appropriateness of this method for this research topic, the purpose behind its usage, and how it is used as a means to explore and generate new concepts related to governance principles. The chapter demonstrates how the Delphi consultations yielded consensus on the selected governance principles' main characteristics and their actual implication in practical terms, thus enriching the tool's content.

The second part of the chapter concerns the consultation meeting with policymakers, its value, participants, outcomes, and the tool's further refinement based on this review.

4.1 Refining the Tool: Delphi Method-Consultation with "Governance Experts"

Since there are conceptual gaps regarding the implications of GG principles in practical terms and a need for consensus as to the aspects that require to be assessed in HSG, the Delphi method was selected. The Delphi method, as defined in Chapter Two, presents a flexible consultation technique executed virtually (usually through the exchange of emails), used to reach a consensus between a group of experts on a complex subject whose field has a limited number of experts, such as governance (Okali and Pawlowski, 2004). In addition, combining expert opinion with evidence from the literature will ensure both face and content validity of the new assessment tools (Campbell et al., 2003, p.818).

The use of this consultation method involves multiple rounds of consultations, wherein each round builds on the results of the previous one and enables referring with the same group of experts from all across the world in an inexpensive way (Keeny, Hasson and Mckenna, 2001). The literature recommends including different kinds of experts, such as academics, NGOs, as well as governmental officials, practitioners, among others (Okali and Pawlowski, 2004).

This group communication is facilitated by a "Maestro", who also controls the feedback (Hasson et al., 2000). Delphi consultations require prior preparation and planning of the steps and facilitation and communication skills, necessary for a successful process (Hasson et al., 2000). Each round serves as a "special type" of survey, in which a questionnaire is created based on the tool developed, sent (usually via email, fax, or some web medium) to a group of experts, and they are asked to fill in the questionnaire, responding to the list of questions over several rounds (Okali and Pawlowski, 2004). The returned responses are then analysed and the questions adjusted accordingly; subsequently, the revised list of questions is sent back and forth among the experts (Okali and Pawlowski, 2004). They will be asked to revise their original responses and respond to another set of questions based on the group feedback; this will be done until a satisfactory degree of consensus is reached regarding the items that should be included in the tool (Okali and Pawlowski, 2004).

Though the literature suggests that the classic Delphi process comprises four rounds, two to three rounds are preferred to avoid overloading the experts (Hasson et al., 2000). I decided to conduct the Delphi consultation over three rounds based on acceptable practice reported by Okali and Pawlowski (2004) and others (Hsu and Sandford, 2007; Kalaian and Kasim, 2012).

4.2 Planning the Delphi

Planning for the Delphi consultations included brainstorming about potential challenges and possible ways to overcome them. The first main challenge was to identify qualified experts in the field of health governance. The second was to attract experts to participate in the Delphi consultations. There were no expectations for a minimum number of experts to be included. The third challenge was collecting group opinions, analysing the responses, and following a controlled feedback process (Hsu and Sandford, 2007) in a timely manner. The literature from various fields offers general guidelines as to ways to develop the questionnaires and conduct analyses based on the scope of the research and the responses received, allowing to modify the classic Delphi process (Hsu and Sandford, 2007). Consequently, I followed a modified Delphi method to suit the objectives of this research.

Planning the duration of the Delphi process presented another challenge. It was necessary to give the experts sufficient time to review the tool in order to obtain the best possible results in terms of number of responders and the review’s quality (Hasson et al., 2000). Thus, it was crucial that the time provided for the review was not short, to prevent

pressurising the experts as this might result in loss of interest in the consultation, and not too long either as it would have resulted in delaying the research. Following Hsu and Sandford's (2007) work, I gave the experts three weeks to respond, and allocated six weeks for each round in total, including receiving responses, analysis, adjusting the tool, summarising the responses, and sharing them with the experts for the consecutive round. The expected period for the Delphi consultation was estimated to be five months (between July and end of November 2015).

The part of the planning phase was to plan for the analysis of the Delphi experts responses. I obtained funding from the WHO for my research and recruited a statistical expert to help with the analysis in order to save time.

4.3 Identification and Recruitment of Delphi Experts

The first step, one of the most critical ones for the success of the Delphi process, was to compile a list of "governance" experts to invite from a diversity of backgrounds. The aim was to generate a list that included experts who were qualified professionals with relevant knowledge, that is, expertise in health governance (Kalaian and Kasim, 2012), who were available, willing to participate (Kirigia, 1996), and committed to be involved in the Delphi consultations over a period of at least five months (Hasson et al., 2000).

The list of Delphi experts comprised three strands. A total of fourteen were from my network (people I either worked with or met during meetings related to governance held by the WHO). These were health governance practitioners, senior health and development consultants, academicians, and ministry officials from a number of countries. Furthermore, ten experts were identified from readings on health governance (due to their contribution to HSG knowledge). Further sixteen were nominated by other governance experts from my network, based on their experience in the field. Therefore, initially, there were a total of 40 experts to be contacted. When I contacted this initial list of invitees, I requested additional recommendations of experts who might be interested in joining this research. Consequently, another 26 experts, nominated by other experts, were added, and I was allowed to use their names as points of reference to contact further experts.

Therefore, in total, I contacted 66 experts from diverse backgrounds from different countries, not limiting the group to LMICs, which thereby led to the creation of a heterogeneous pool of experts.

They were contacted via email, which was a challenge by itself. The email sent was brief, with information about the study and what was needed of the experts presented in bullet points. The email included an attachment with an information sheet for participants (see Annex 2); furthermore, they were asked to send their consent to participate in this research via email.

In addition, these experts were asked if they would agree to reveal their names to other experts. The common practise is that experts do not know the identities of other experts throughout the process while the researcher is aware of them (Okali and Pawlowski, 2004). Revealing other experts' to experts while keeping their individual responses anonymous constitutes quasi-anonymity and is a practise recommended in Delphi consultations as it can encourage more experts to join and remain engaged in the process (Okali and Pawlowski, 2004). In fact, all the experts who joined the Delphi agreed to reveal their names to others and have their names published in all future acknowledgments.

As can be seen in Table 4 below, 30 (45.5%) experts who were contacted showed interest in participating in the Delphi consultation; however, when the consultations started, only 25 (38%) responded to at least one round. The literature suggests that from 60 to as few as 15 can be an acceptable number of Delphi experts (Hasson et al., 2000), and thus the number involved in the current research can be considered acceptable.

Table 4: Experts Recruited Based on Personal Contact or Referred by Others

	Who Agreed to Participate	**Total Number Contacted**
Prior Personal Contact	12	14
Referred by Others	17	42
No Previous Contact and No Reference	1	10
Total	**30**	**66**

Out of those who agreed to participate, initially, I had prior personal contact with 40% of them, 56.6% were referred by others, while only 3% (one person) agreed to participate despite no personal contact or referral by anyone. The latter dropped out after the first questionnaire was sent, thus reflecting other findings regarding the importance of "gatekeepers" (Hasson et al., 2000) in the recruitment of experts. This could have resulted in a biased pool of experts, those who agreed to participate; however, the sample was sufficiently heterogeneous (in terms of level of expertise, status, seniority, institutional

affiliations, and countries worked in, details provided below in the Delphi Expert Profile section) to overcome this bias, and all experts satisfied the criteria determined for the profile of experts required.

Log sheets were maintained for all consultation rounds, indicating the time when the questionnaire was first sent, their feedback was received, reminders were sent, and reasons for withdrawal wherever applicable.

- *Delphi Expert Profile*

There were 25 active Delphi experts who participated in at least one round of Delphi consultations, a number considered acceptable by other researchers (Hamilton, Rubin and Singleton, 2012) (see Table 5 for the Delphi experts' general profiles).

Table 5: Delphi Experts' General Profile

Sectors They Served in	• 3 from the public sector: MoH, governmental anti-corruption agency, and parliamentary member • 8 from international organisations: 4 WHO and 4 USAID • 8 From academia • 2 From local NGOs • 1 from international NGOs • 2 independent consultants • 1 professional organisation
Countries of Current Employment	Algeria, Australia, Bolivia, Brazil, Egypt, Jordan, KSA, Lebanon, Mexico, Morocco, Philippines Portugal, Sudan, Switzerland, Tunisia, USA
Years of Experience in Health Governance Issues*	• 2 < 5 years • 6 between 5–10 years • 2 between 11–15 years • 1 with 25 years of experience;1 with 40 years of experience

*Not all experts indicated years of experience in the field of governance

The group of experts included 12 females and 13 males, which is, again, an acceptable gender balance. The group of experts represented various disciplines and organisations currently working in 16 different countries as indicated in the table above (for further details, also see Annex 3: List of Delphi Experts and Affiliation). The countries where the experts had worked in or assisted in governance issues was even more diverse.

Experts' experience in health governance issues was wide-ranging and included health financing and planning, governance of civil society organisations, design and implementation of health governance interventions and evaluation of their effectiveness in capacity-constrained and fragile environments, strengthening pharmaceutical systems in

LMICs, strengthening health systems and health reforms, with an emphasis on smarter governance, conducting procurement assessments in health, development and execution of integrity risk assessment focusing on transparency and accountability, policymaking at the national level, development and delivery of training on governance in health, teaching and supervision of masters dissertations related to governance in health.

Hence, the group of experts involved in the Delphi process was heterogeneous and appropriate for it's the objective of the consultation, reaching a consensus from among multiple perspectives on HSG issues. The literature recommends representation of this kind to allow multiple perspectives concerning the topic under study (Okali and Pawlowski, 2004; Hasson et al., 2000). The inclusion of 25 experts with diversity in terms of years of experience (some junior and some very senior), type of organisation, and type of expertise (academia, professionals) contributed to the development of the tool's content. The experts had different backgrounds in terms of the countries they came from and worked in, coming from low-, middle-, and high-income countries. Learning about GG practices in high income countries was useful while the perspective as to what will be practical in middle- to low-income countries was extremely important and informative for the development of a practical tool.

Reaching a consensus in a group this diverse was a challenge; yet, it was highly important and needed since it would reflect different perspectives regarding HSG based on these experts' practices. The only limitation in the group of experts was an inadequate number of senior-level policymakers (there were only three), whose recruitment proved to be a difficult task. Policymakers feedback concerning the tool was essential as they would be the end users of the results/recommendations of this research. Fortunately, this gap was addressed through a consultation meeting held with policymakers, which took place after the Delphi process (discussed in detail in the second part of this chapter).

The literature suggests forming various panels of experts based on their fields of expertise (academics, practitioners, governmental officials, and official NGOs) (Okali and Pawlowski, 2004); however, in this research, it was not possible to form such panels due to the limited number of experts in the field of health system governance and the imbalance in the number of experts based on their work experience. Most of the participants work in international organisations and academia and a lesser number belonged to governmental agencies and NGOs. Instead, the experts were divided into groups, depending on the principles they decided to review, that is, there were five groups, one for each of the five principles. The following section provides a description of the Delphi process and analysis

of the responses received from the three rounds conducted and the outcomes and the way in which the tool was refined according to these consultations. A summary of the Delphi process has been presented in Figure 3, p: 113.

4.4 Round 1

This round commonly involves brainstorming for important/relevant factors in an "idea generation" activity (Okali and Pawlowski, 2004). The experts are asked open-ended questions in the first round in order to obtain a list of relevant aspects the tool should cover (Okali and Pawlowski, 2004). This round was modified for this purpose as recommended in other literature (Hamilton, Robin and Singleton, 2012). Instead, the individual experts were provided sets of questions (regarding the characteristics of each of the five principles) and were asked whether they considered them relevant or not. This was done, first and foremost, to provide a theoretical background based on the literature so as to have a solid conceptual starting point for the tool and also to limit the number of rounds that might be required for the consultations. The limitation of providing pre-existing information (questions) rather than starting with open-ended questions is that this could result in biased responses as it limits the available options that can be explored (Hasson et al., 2000; Okali and Pawlowski, 2004). This limitation was addressed by asking experts to suggest questions that could be added and had not been considered initially.

4.4.1 The Purpose of Round 1 Consultation

The purpose was to assess the tool's comprehensiveness and the five principles' main characteristics' relevance at the level of policymaking. Additionally, identify any missing aspect, obtain feedback on the proposed structure of the tool, clarity, and suitability of the questions' wording.

Asking the experts to justify their responses is considered an optional yet valuable step in the literature for expanding the theory and is thus desirable (Okali and Pawlowski, 2004); therefore, justifications were requested in this Delphi consultation.

4.4.2 The Process of Round 1 Consultation

The experts were asked to choose and review at least two out of the five principles selected for the tool; this was done to prevent overburdening them with lengthy review of all principles. All the principles were chosen for review but not in an equal number (see Table 6 below).

After the experts indicated their preferences, they were sent the assessment tool with the sections selected with an instruction sheet (see Annex 4: Delphi Round 1 Tool). The first draft of the tool was sent as a generic one, in which the policy area (e.g. drug policy, maternal health, cancer services, among others) was not specified. Reminder emails were sent to them before and after the deadline. Sending reminders to experts is recommended in literature to increase the response rate (Hasson et al., 2000). While the experts were provided three weeks to send their responses, some were delayed, as anticipated. All responses of experts who sent their feedback were included in the analysis.

4.4.3 Feedback

Out of those who agreed to be a part of the Delphi consultation, 73% sent their comments in Round 1. People who did not send their feedback and did not provide a reason for doing so were considered as "dropouts", while those who did not send their feedback but explain the reason behind it were considered to have "withdrawn".

A total of five experts withdrew from Round 1 consultation: two due to medical problems, two were busy travelling, and one had some personal problems. furthermore, three experts dropped out without any explanation since they never responded to the reminder emails.

Table 6 summarizes the number of experts who reviewed the various principles across the three rounds of consultations and the total number involved in each round.

Table 6: Number of Reviewers per Principle across Three Rounds of Consultations

Section	Round 1 Number of Experts	Round 2 Number of Experts	Round 3 Number of Experts
Participation	13	14	10
Transparency	12	10	8
Accountability	10	10	9
Information	10	8	7
Responsiveness	9	11	7
General Comments	2	1	---
Total Number of Experts	**22**	**21**	**15**

Okali and Pawlowski (2004) suggested including 8 to 18 experts per panel, which means that there was an acceptable number of experts in all rounds, except for Round 3, as a substantial number of withdrawals/dropouts took place.

Over the three rounds of consultations, 25 experts were involved. In total, 18 experts reviewed two sections, three reviewed three, and four were asked to review the whole tool (five sections).

Two experts offered general comments regarding the principles they reviewed and not individual questions. Nearly all the others answered the question whether individual questions were relevant or not relevant; some suggested specific changes to the questions, and few also added justifications for their choices. In addition to the specific comments, several general comments were provided on the tool as a whole.

4.4.4 Analysis and Outcomes

The analysis of the responses received in round 1 included only a simple counting of the questions marked as relevant as against not relevant within each principle/section. Based on these, the percentage of agreement to retain and remove questions across the five principles were calculated by me.

- *Questions to Be Removed*

Any question that was labelled as not relevant was considered as a suggestion for removal. It was decided that questions that at least two experts had labelled as not relevant would be removed. The agreement to remove a question was calculated as the percentage of experts who answered "not relevant" against the total number of experts who reviewed the principle. This decision was made to shorten the list of questions as much as possible.

The percentages of agreement to remove a question across the five principles ranged from 15.4% to 44.4% (average 24.3%). In most cases, the questions that were removed were duplicates either within the same principle, especially PBQ or because they appeared under other principles. A few were suggested for removal due to practical issues such as being difficult to assess (see Table 7 below for these questions).

Table 7: Questions Suggested to Be Removed Due to the Difficulty in Assessing Them

Principle	Questions Suggested for Removal Due to Difficulty in Assessment
Participation	Is it specified in the mandate of the committee the level of participation? Consultation, partnership, delegated power, and control Is there a mechanism for consensus building between various stakeholders?
Transparency	Are there written criteria for decision-making in relation to policy formulation?
Accountability	Are justifications included during evaluation/monitoring?
Use of Information	How has evidence-based research been utilised in policy formulation? Instrumental, conceptual, symbolic use, not used

- *Questions to Be Retained*

Questions were retained if all the experts or all except one labelled these questions as relevant. The agreement to retain questions across the five principles ranged from 89% to 100%. This signifies means that any individual question retained received more than 70% agreement regarding its importance, as recommended by Okali and Pawlowski (2004).

- *Questions to Be Added*

It was also decided that new questions will be added for assessment during Round 2 based on experts' individual requests. The concepts that were suggested for adding to the tool across the five principles and were thus added to the final draft of the tool have been provided in Table 8 below.

Table 8: New Concepts Suggested for Addition per Principle: Round One

Principle	Concepts Suggested for Addition
Participation	• Gender balance between stakeholders participating in formulation • Presence of dedicated resources to enable/facilitate participation • Presence of a participatory body to oversee policy implementation • Presence of mechanisms to enable vulnerable groups' participation
Accountability	• Requirement to sign a contract/memorandum of understanding (MOU) with stakeholders before engaging them in the formulation process • Stakeholders should be informed before their engagement that they will be held accountable • The public should hold various stakeholders accountable for their role in policymaking
Transparency	• Decisions related to priority setting should be made public • Decisions related to resource allocation should be made public • Conflict of interest (COI) declaration should be made by all stakeholders • Information should be released in a "predictable manner"
Use of Information	• MoH should make the data generated at service delivery level accessible to researchers • MoH should have a mechanism in place to check the sources of funding for research used in policy • Information about how national evidence is generated and MoH adapts research findings to local context should be disseminated

Responsiveness	• Need assessment targeting the public should be undertaken as a part of policy formulation • Health policy should be assessed to ensure that it meets the population's needs

The justifications offered the Delphi experts for the concepts added across the five principles were as follows.

- *Concepts Added to Participation*

Gender balance: It is necessary to highlight the importance of women's participation in the policymaking process, thereby ensuring fair representation. In some countries, females are highly discriminated against and their voices are not heard, while in others, this is not the case. Therefore, identifying whether this is the case with regard to policy formulation in a certain country reflects on stakeholder participation and representation, which will affect policymakers' recommendations.

Presence of dedicated resources: Resources need to be available in order to facilitate and pay for the expenses of meetings (venues, coffee breaks, and other meals) as well as administrative work or material (print outs, among other things) related to meetings (Smith and Katikireddi, 2013; Matthews, Pulver and Ring, 2008). Furthermore, it is recommended that incentives be offered for participation in the form of a fee or honoraria or at least provide reimbursement for transportation and accommodation, as ways to encourage participation and commitment (Emerson, Nabatchi and Bologh, 2011). This is because lack of participation may have been caused due to the absence of dedicated resources, and hence, these should be provided to cover the relevant costs.

Participatory body for implementation: Participation should continue throughout the policymaking cycle to ensure ownership, which can thus enhance the possibility of success in policy implementation (Emerson et al., 2011). Stakeholders' oversight in policy implementation is crucial to the process.

Enabling participation of vulnerable populations: There should be mechanisms in place to offer vulnerable groups an opportunity to participate in decision making related to their health or at least be consulted and heard. Accordingly, the MoH/Health authorities should make some kind of investment to help enable the participation of the most vulnerable groups as they may not have formal education or the skills required to raise their voice.

- *Concepts Added to Accountability*

Informing stakeholders that they will be held accountable: The various stakeholders should be informed before being engaged in the policy formulation and implementation process about their roles and responsibilities.

Signature of Memorandum of Understanding (MOU)/contract: This should be done to ensure the accountability of all stakeholders, and this can be done by ascertaining that all stakeholders are informed about their duties, roles, and responsibilities in a written form.

Public role in holding stakeholders accountable: There is a need to establish mechanisms for citizen oversight in policymaking (Brinkerhoff et al., 2008) through health boards or other means to allow the public to demand explanations regarding certain health issues or decisions.

- *Concepts Added to Transparency*

Decisions related to priority settings and resource allocation should be public: Accessibility to such decisions is a sign of transparency (Otenyo et al., 2004; Relly and Sabharwal, 2009) and necessary to ensure proper accountability and increase public's trust in government decisions.

Information released in a "predictable manner": Predictability is one factor that must be included in transparency. It signifies that relevant stakeholders and the public can have definite expectations as to when they will receive information. Accordingly, there should be published timelines, which should include what to expect in the relevant information and when to expect it.

Conflict of interest declaration: Participants should declare their affiliation and any relationship and/or remuneration that might influence their participation and contribution to the policy development and implementation, another sign of transparency (WHO, 2009). This declaration does not imply that they do not have the right to participate and offer their feedback. In reality, most stakeholders will have a conflict of interest; it is an inherent issue as actors and experts in the health system. If only neutral parties are consulted, then stakeholders' real positions would not be captured. It is only a matter of declaring these conflicts to everyone involved to be transparent about it.

- *Concepts Added to Use of Information*

Making raw data accessible to researchers: A part of governance entails sharing information required to inform policies and conduct relevant research. Data generated at the health facilities should be easily accessible by researchers and made available to them.

The reason behind this proposed addition could be the fact that the majority of Delphi experts from academia selected this principle and thus the addition of this question appeared reasonable to all.

Checking the source of funding of research: It is important for MoH/health authority to have a mechanism in place to ascertain whether the research conducted for policymaking is financed by a private or any other entity that has a conflict of interest in relation to the policy in question.

National evidence generation and adaptation: The way in which evidence is encouraged and generated at the national level and the factors that affect its generation are important pieces of information. Moreover, the ways in which they can be adapted to the context of the policy in question specifically and to the country in general are issues that need to be taken into consideration.

- *Concepts Added to Responsiveness*

Needs assessment targeting the public as a part of policy formulation: The assessment of the health system's responsiveness should be based on consumers/users' feedback as they represent the best source of information. This implies that it is important for policymakers to understand the public's perception as well as preferences with regard to the health system and allow them to express their needs (Darby et al., 2000; Siddiqi et al., 2009). This assessment is suggesting the use of surveys, public forums, telephone hotline, or any other appropriate means.

Health policy should be assessed to ensure that it meets population needs: It is important to be able to assess the various elements of responsiveness as a part of the specific policy under evaluation. Determining whether the policy in question satisfies people's expectations comprises an issue of governance and thus should be included in the evaluation phase.

It is important to highlight that Most of the concepts suggested (see Table 8) for addition were not found in the literature reviewed. They were suggested based on their significance in practice; furthermore, the Delphi experts were asked to approve their addition to the tool in subsequent rounds.

The specific comments and suggestions regarding the retention of individual questions guided the modification of the questions, which included rephrasing (as some questions were vague and required further elaboration), editing and rewording (to enhance clarity), as well as rearrangement. Some questions were merged with others as they covered the same

concepts. The general comments received on the tool as a whole (whether addressed or not) have been summarised in Table 9 below.

Table 9: General Comments Received by Delphi Experts during Round One

General Comments Addressed and How
• Specify a policy type as an example to make the review easier: *National Health Strategy was chosen as an example* • Relate questions to different phases of policy process: *Questions were in relation to formulation phase* • Define five principles: *Detailed definitions were added* • Define policy and policymaking: *Definitions were added* • Tool is excessively long: *One of the objectives of the Delphi consultation was to make it shorter* • Some questions are redundant and repetitive: *Duplications were removed* • Some questions can be merged: *This was done to questions that covered same concepts* • Some questions require filter question with sub-questions: *This was done for many EBQs* • Sequence of questions needs to be revised: *Revisions were made to reflect a more logical sequence* • Tool requires pre-testing: *A pilot was planned* • Need a sampling strategy of KIs to include different categories and data collection protocol: *These were developed as a part of the manual* • Tool does not reflect the broader country context: *Information regarding the country's context and health system structure were included in the report*
General Comments that Were Not Addressed and Reasons for It
• Two reviewers suggested removing responsiveness since there was a great amount of overlapping with other sections and this would form a conceptually weak: *I believed in the importance of this principle for its inclusion and testing (further details provided in the section below).* • Data collection through desk-review alone would be difficult: *The decision regarding the best data collection method was postponed till after the finalisation of the tool's content.* • Need to provide incentives for KIs: *Uncertain whether it is ethical to provide financial incentives to KIs as it is believed that their incentive is improving the policy process.* • Classify questions into categories such as legal framework, operational management, and others: *It was deemed inappropriate to group questions further as they were already grouped in accordance to the five principles.* • Use Likert scale for EBQs: *One of objectives of the tool is to produce lists of good practices to follow, and the use of Likert scale would not enable this approach.* • The focus is on policy formulation only, but other aspects require to be addressed as well: *The tool is already an elaborate one since it explores considerable detail and thus cannot cover other phases of the policy cycle.* • The assessment of reliability and validity is difficult with such tools: *Validity testing was undertaken as a part of Delphi process in terms of content. Testing reliability was recognised as an issue and will be discussed later.* • Assign a score that places each country on a continuum of weak or good governance: *This step was planned but the final decision was left to policymakers for a later date, and they voted against this alternative.*

With regard to the section on responsiveness, two experts out of the nine who reviewed it during Round 1 suggested that it should be dropped from the tool since it is conceptually weak as compared to the other principles. This could be due to the fact that was not adequately developed at the conceptual level in the literature: it defines responsiveness at the service delivery level only (as discussed in Chapter Three). Responsiveness is defined by several scholars/institutions as being responsive at the policy level, whereby "institutions and processes should try to serve all stakeholders to ensure that the policies and programs are responsive to the health and non-health needs of its users" (Siddiqi et al.,

2009, p.18). Governments/MoHs are obliged to listen to the needs of their citizens, act on their concerns, and respond to their expectations in policy development (Darby et al., 2000; Ura and Ellis, 2008). Additionally, there is a lack of literature to support what responsiveness really means in an operationalised way. These reasons contributes to its inadequacy. However, due to this deficiency, I decided to retain it in the tool in order to allow an opportunity for its conceptual development with the help of governance experts. This step is considered suitable as it is consistent with the objective of this research and the tool, whose aim is to increase the understanding of GG at the level of policymaking by uncovering the significance of its principles in depth. The experts were informed that it will be retained for these reasons, and none of the eleven experts who reviewed it in Round 2 objected to this decision. Thus, despite some reservations, the majority saw it as an important principle and the literature offers a considerable amount of evidence to support this view (Darby et al, 2000, Gostin et al., 2003; Siddiqi et al., 2009). Therefore, it was decided that it will be retained in the tool. Moreover, the research process would facilitate the identification of its characteristics for further conceptual development. Responsiveness' conceptual development in the tool has been discussed in the section on Round 3.

4.5 Round 2

4.5.1 The Purpose of Round 2 Consultation

The purpose of this round was to reach a consensus regarding the questions to retain, add, and remove as well as shorten the list of questions in order to have a practical tool. Round 2 consultations offered the Delphi experts an opportunity to revise and validate their initial responses to the individual questions, confirm or modify them, based on the collective responses of other experts (Kalaian and Kasim, 2012). As recommended in the literature, the inclusion of an aggregated summary of experts' feedback received is the most common practice in such consultations (Keeney Hassoun, and McKenna, 2001; Holey et al., 2007; Hsu and Sandford, 2007). As stated earlier, this allowed the experts a chance to revise the implemented changes based on the responses from Round 1. Thus, the modified tool for Round 2 consultation included three subsections pertaining to each of the five principles.

- Questions to be retained
- Questions to be added
- Questions to be removed finally from tool

4.5.2 The Process of Round 2 Consultation

Delays in receiving feedback from Round 1 led to the postponement of Round 2, which resulted in reduced time for sending feedback (18 days instead of 21). All the 22 experts who sent comments on Round 1 were invited to participate in Round 2.

Furthermore, three experts (who were contacted at the start of the Delphi process and exhibited an interest in participating but dropped out) asked to join Round 2. They were considered "new comers" since they did not need to participate in Round 1 (Hamilton, Rubin and Singleton, 2012). Consequently, a total of 25 experts were consulted for Round 2.

A three-page introduction was added to the tool in a bullet-point format along with a summary clarifying a number of issues (as illustrated in Table 9). The instructions provided to the experts were specific and simple to follow so as to make the review process as convenient as possible but at the same time systematic as well.

For this round of consultation, the experts were sent the principles/sections they had previously reviewed (during Round 1), and they were informed that each principle currently contained three subsections/parts (as mentioned above). Furthermore, they were specifically asked to do the following:

- **For retaining questions:** They needed to rate the importance of the questions on a Likert scale (1: not important, 2: little significance, 3: average importance, 4: important, 5: very important) similar to what was previously used in Delphi (Australian Institute of Health and Welfare (AIHW), 2009).
- **For adding questions:** Consensus was required for this. If it was agreed that it was to be added, the importance of each question was required to be rated with a Likert scale (as done above).
- **For questions to be removed:** Decisions needed to be made regarding whether certain questions should be removed and justifications were required in cases not agreeing to remove.
- Experts were also asked to add general comments regarding the second draft of the tool in comparison to the first draft.

All of the experts' responses gained over the three rounds were entered in Excel sheets and sent to the statistician for analysis after rounds 2 and 3. The tool was not sent to him, only the coded numbers for the questions with the responses, thus making the process blinded.

The spreadsheets facilitated the systematic monitoring of questions that different experts rated differently at different points in time (mainly between rounds 2 and 3).

4.5.3 Feedback

Out of the 25 experts who received draft 2 of the tool, 21 sent their feedback and comments. In this group, three dropped out without any excuses and one withdrew due to prior engagements (see Table 6 for the number of reviewers per principle in Round 2). A few provided justification for their suggestions to add or remove items similar to Round 1. A two-week delay was experienced in receiving the responses compared to the one-week delay in Round 1.

General comments concerning the tool included concerns regarding the length of the tool, processes followed to conduct the tool at the national level, difficulties involved in some questions through a desk review, suggestions to include a general section of the tool to offer an overview of the country's context, and overlap between principles and some repeated questions. Furthermore, a total of ten experts commented that the tool was improved in terms of the questions' coherence, wording, clarity, and the robustness of the tool in general.

4.5.4 Analysis and Outcomes

Earlier work on Delphi consultation recommend the production of descriptive statistics based on an analysis of questions' ratings by experts in order to gain statistical summaries for each (Hassoun et al., 2000; Holey et al., 2007). These include mean, median, and standard deviation (Hassoun and Keeny, 2000), percentage response rates, as well as agreement percentages (Holey et al., 2007) and the coefficient of variance (CV) (Kalaian and Kasim, 2012), which were produced for Round 2 analysis. The application of simple statistics offers the advantage of sharing aggregated summaries of the feedback along with justifications for decisions made that were presented to the Delphi experts in a user-friendly manner. This was crucial to the success of the method practised or applied from a distance as it would have been difficult to explain or present complicated statistics if they were required.

For removal of questions: Agreement concerning the removal and change in agreement on removal of questions between rounds 1 and 2 was calculated as percentages (as discussed in the analysis of Round 1). It was found that agreement on the removal of suggested questions in this round ranged from 54.6% to 100%, with an average of 81.2%. Hence, the majority of experts agreed on removing the suggested questions. This is an indicator of a consensus among other experts, which is essential for the success of Delphi consultations (Hasson et al., 2000). This also represents a large increase in agreement from Round 1, in which the average on removal was only 24.3%. This demonstrates an advantage of Delphi that is reflected in the group dynamics that take place, wherein experts tend to change their opinion in line with others' views (Hassoun et al., 2000) to reach the required consensus. Certainly, the aim is not to reach a consensus for the sake of it, rather, to gain experts' contributions towards the identification of items not relevant or those that are duplicate and thus redundant. Questions were removed if they received agreement exceeding 70% for removal; as Okali and Pawlowski (2004) suggested, this presents an acceptable level of agreement.

For retention of questions: The median, standard deviation, and CV were computed for each question (Hasson et al., 2000). Furthermore, the average rating (the sum of the ratings divided by the number of questions) based on the rating of importance as made by the experts was calculated for all questions within a subsection for each of the five principles (Kalaian and Kasim, 2012). Moreover, within each subsection, questions were ranked according to value of the CV, with 1 being the greatest (indicating the highest variability among experts in rating items). All of these were calculated to determine if consensus was reached among experts by identifying questions that received the highest rating in importance, lowest rating in comparison to the mean/average ratings, and variations in ratings among experts with the CV.

Questions that were retained received an average rating equal to or higher than the average rating of that given subsection. This cut-off point was determined by the statistical expert and myself. Furthermore, questions that received the highest CV (high variability among experts in terms of importance) were removed. Moreover, the questions that received 70% or more in agreement were retained in the tool.

For addition of questions: The percentage of agreement on adding new questions was calculated for each question within each subsection, which ranged between 54.6% and 100.0%, with an average of 75.3%. This indicates that the majority of experts approved the addition of the individual questions. Only questions that received an average rating equal

or above the average rating of the corresponding subsection were added. Thus, questions with the lowest average rating were not added. In addition, questions with the highest CV were not added to the tool as well as this indicates variation in rating of importance by experts (disagreement on importance).

The experts suggested 44 questions (23 evidence-based and 21 perception-based) in Round 1 for addition as important aspects that required to be covered. Based on the analysis discussed above, a total of 30 questions received agreement for addition (see Table 10 for the number of questions before and after Round 2). This implies that experts agreed to take on 68% of the suggestions. This addition of new questions represents new information gained from the Delphi consultation (Kalaian and Kasim, 2012), which contributed to the broadening of knowledge concerning the topic under study (Hasson et al., 2000). Thus, Delphi consultations were not only employed to reach consensus on concepts identified from the literature but also to generate knowledge by allowing experts to express opinions and offering them a chance to conduct mutual reflections and gain feedback. This contributed, to some extent, to the development of a pragmatically usable and policy-relevant tool, which is also substantively robust in relation to the literature Overall, the experts agreed to remove 35 out of 44 questions (i.e. 79.5%) that had been suggested for removal during Round 1. This implies that out of all those suggested for removal during Round 1, only 9 (four EBQ and five PBQ) were retained for Round 3 as they did not receive consensus of 70% or more among experts for removal (see Table 10).

Table 10: Number of Questions to be Retained, Added, or Removed before and after Round 2

	Before Round 2		**After Round 2**	
	Evidence-Based Questions	**Perception-Based Questions**	**Evidence-Based Questions**	**Perception-Based Questions**
Questions to be Retained	52	45	44	32
Questions to be Added	23	21	15	15
Questions to be Removed	23	21	19	16

The Delphi consultations resulted in a decrease in the number of questions from 89 to 63 for EBQ and from 69 to 52 for PBQ. As mentioned earlier, the significance of reducing the number of questions within the tool is to render it practical and applicable, as highlighted by the Delphi experts.

4.6 Round 3

During this round, consensus between experts was expected on the final list of questions to be retained, and if consensus cannot be reached, adjusted lists of questions would be resent for further consultation until the point a consensus or plateau among the different experts is attained (Okali and Pawlowski, 2004).

4.6.1 The Purpose of Round 3 Consultation

To reach a consensus among experts on the final draft of the tool to be pilot-tested.

4.6.2 The Process of Round 3 Consultation

Delays in receiving the feedback from the experts in Round 2 resulted in delays in the analysis and the adjustment of the tool for Round 3. Consequently, the experts were provided less than three weeks (19 days) to send their feedback. The tool was sent to 20 of those who had sent their comments on Round 2 (one asked to withdraw after Round 2).

The tool itself included a five-page summary concerning the way in which this draft was adjusted, general clarifications, statistical analysis conducted for Round 2 responses, the purpose of Round 3, and what was requested from the experts.

They were also informed regarding a few questions that were retained in the tool despite receiving a lower average rating than the average rating of the relevant subsection as these were considered "fundamental" inquiries based on the literature review. I decided to retain these questions for one more round of consultation and informed the Delphi experts regarding this decision in order to be transparent and allow room for further discussion (see Table 11 below for these questions).

Table 11: Questions Retained Despite Their Lower Average Rating

Principles	Questions Retained Despite Low Rating	Rating Received/Question against Average Rating of Importance/Section
Participation	Is there a written scope/mandate for stakeholders' involvement in the formulation of health policy?	4.31 vs. 4.43
	Are other mechanisms used by MOH/health authority to encourage participation by different stakeholders?	4.38 vs. 4.43
Accountability	What are the types of sanctions applied/might be applied to bodies responsible for implementation of various sections policy X in case of violation/not adhering to set standards?	4.18 vs. 4.47

Transparency	Does the document relating to policy X include the following: how policy was formulated, objectives, purpose and goals, evidence used, how decisions were made/justifications, the body responsible for policy, clear distribution of responsibility for implementation, timeframe for implementation, indicators and targets and plans of M&E, funding requirements?	4.44 vs. 4.46
	Did the participants declare any conflict of interest by signing an official form?	4.14 vs.4.46
Use of Information	Does MoH/health authorities have a mechanism in place to check sources of funding for research to be used in policy?	4.2 vs. 4.42
	Were other types of information (other than research) utilised in the policy formulation of policy X?	4.33 vs. 4.42

As can be seen from the table, the lower average rating received for each individual question is slightly lower than the average rating of importance for the whole subsection (average rating of the section was set as a cut-off to remove questions as discussed in Round 2). All questions retained despite the lower average rating received an average rating above 4 (4 is important) on the scale of importance from 1 to 5 (5 is very important).

The justifications for retaining the questions presented in Table 11 based on literature the has been given below.

- *Participation*

With regard to the written mandate/scope: A written mandate that includes SOPs, by-laws, decision rules, conflict resolution mechanisms is necessary to ensure clarity regarding roles and responsibilities (Cornwall et al., 2001). There is a need for shared commitment, motivation, set of values, and goals, determined from the beginning (Emerson et al., 2011). In order for the mechanisms to encourage participation, the government is responsible for creating and facilitating mechanisms, spaces, and places to promote participation of interested citizen (Papadopoulos and Warin, 2007). Engaging the public requires government planning and resources (Bishop et al., 2009). Different methods/mechanism/strategies can be utilised to encourage citizens' participation (Charles and de Maio, 1993; Mitton et al., 2009; Oxman et al., 2009).

- *Accountability*

With regard to the types of sanctions, for meaningful accountability, all the following components are required: setting standards, investigation and answerability, allowing justifications, including sanctions, as well as including enforcement mechanisms (Brinkerhoff, 2004; Murthy, 2008). Policymakers should be aware of all the types of sanction they can enforce based on their authority under law (Murthy, 2008).

For methods to foster/enable accountability: Several mechanisms are suggested, which should be used to enable and facilitate their enforcement (Tuohy, 2003; Ebrahim, 2003; Taryn, 2008; Brinkerhoff and Bosart, 2008;).

- *Transparency*

For priority decisions to be made public: The availability of such decisions is a sign of transparency (Otenyo et al., 2004; Relly and Sabharwal, 2009). With respect to the components of the strategy document, the content of the information forms another important criteria for transparency; the policy document essentially reflects transparency in the formulation and implementation plans (Otenyo and Lind, 2004; Taryn, 2008; NAO, 2012). In relation to conflict of interest (COI), participants declaring their affiliation and any relationship and/or remuneration that might influence their participation and contribution to the policy development and implementation also constitutes a sign of transparency; however, this declaration does not imply that they do not possess the right to offer their feedback (WHO, 2009).

- *Use of Information*

Regarding checking the source of funding: It is important for the MoH/Health authority to have a mechanism in place to ascertain whether the research used is financed by a private entity or any other with a conflict of interest in relation to the policy in question (this was the rationale given by a Delphi Expert). For using other types of information, expert opinion, financial information, governing laws, political direction, and others can be used in policy formulation in addition to scientific evidence (Oxman et al., 2009). They can be utilised on a regular basis and in emergencies at all levels of the policymaking process, being made available to all interested stakeholders (WHO, 2007a, Ch.3).
In conclusion, I believe that these questions required to be retained as they are important aspects of HSG and their application is feasible in real settings. Hence, they were proposed for further consideration during Round 3 by the governance experts.

In addition, during Round 3, next to each question, the average rating of importance calculated during Round 2 was inserted. The statistical information was shared with the experts in Round 3, first, for transparency concerning the analysis and the decisions taken, and second, to highlight the questions that gained collective agreement (Hasson et al., 2000); this was done so that they could compare their opinions with those of the rest of the group (Okali and Pawlowski, 2004).

Experts were asked to do following for this round; For each of the EBQ Section A and PBQ Section B:

To review the questions and the average rating of importance and rate the importance again (as in Round 2) with a Likert scale. They were asked to do so to assess the consistency between rounds as well as evaluate the reflective re-rating based on the feedback of the group of experts.

To rank the importance of each of the questions (Hsu and Sandford, 2007; Okali and Pawlowski, 2004) in relation to others within the same section, 1 being is the most important within a given set of questions, 2 following in importance, and so on, with all numbers being utilised once. The reason they were asked to rank as well as rate was to have two ways of assessing questions' importance, and most importantly, ascertain whether there was a sufficiently high degree of consensus on the final list of questions in order to be able to terminate the Delphi consultation.

To provide general comments and raise any issues to consider in the pilot testing of the tool.

4.6.3 Feedback

Out of the 20 experts who were sent the third draft of the tool, only 15 responded: three dropped out with no excuse and two chose to withdraw (one for medical reasons and the other due to prior engagements) (see Table 6 for the number of reviewers per principle). The final response was received 17 days after the set deadline.

Even the general comments provided during this round were fewer in number compared to the other two, with only eight people offering general comments. Almost all who sent responses in Round 3 did not send any particularly critical comments regarding the tool; rather, they basically confirmed their Round 2 responses.

It was evident from the responses received in Round 3 that there were incomplete data, experts lost interest in reviewing the tool, or they were simply overwhelmed or preoccupied. There was a clear decrease in comments and justification as the rounds progressed; the maximum number of comments were received in Round 1, while the least were received in Round 3. According to the literature, this is termed as "sample fatigue" (Hasson et al., 2000), which was expected at this stage of the consultations and so was the number of experts who dropped out from rounds 2 to 3.

The general comments received during this stage were as follows: "Tool is shaping out to be very comprehensive and yet easy to follow." "Tool improved greatly since first round, but it continues to be long." "Overall tool has kept and refined relevant questions, and with pilot testing it will become clearer." "Some questions still need to be merged and made shorter." "After the Round 3 consultation tool is now ready and is efficient." "Tool now is more succinct and has a better flow." "Tool is becoming more and more precise.".

All the responses of experts' rating for rounds 2 and 3 as well as the ranking for Round 3 were entered onto the same Excel sheets to facilitate the comparison of responses and analysis. The Excel sheet was sent to the statistical expert for analysis, and he was blinded, similar to the second round.

4.6.4 Analysis and Outcomes

The analysis for the rating was conducted as follows:

1. For each question, the average rating for rounds 2 and 3 by the experts who participated in both (Wilcoxon signed rank test) was calculated. The Wilcoxon test is a nonparametric statistical method recommended in the literature for use in the Delphi process for a sample size of experts in different panels lesser than 30 (Kalaian and Kasim, 2012).
2. The percentage of experts who gave a rating of 5 in Round 2 and in Round 3 again (McNemar's test) was calculated. The rationale for deploying the McNemar's test is the same as that for the Wilcoxon test: to ascertain any change in opinion between rounds 2 and 3 (Kalaian and Kasim, 2012). The Wilcoxon and McNemar test results revealed no change in experts' opinion between rounds 2 and 3, thus indicating stability, which refers to "consistency of answers between successive rounds of study" (Holey et al., 2007, p.60). The results demonstrated that while for the majority of the questions the average rating decreased, none of these decreases were statistically significant. Similarly, for the majority of questions, the percentage of 5 as the rating decreased; but, again, none were statistically significant.
3. The kappa statistic, which was also used to measure the level of agreement between rounds 2 and 3 ratings, was calculated. The higher the kappa value, the better the agreement. In general, a kappa exceeding 0.25 is considered to signify weak to fair agreement, one below this figure implies no agreement, while a kappa value of

lower than zero signifies a complete change in opinion (Hsu and Sandford, 2007). In the sample, kappa varied from negative to positive. Some of the experts changed their opinions, whereby instead of giving 5 (most important) as they did in Round 2, they gave a rating of 4 (important) in Round 3. Although the literature recommends using Kappa to take decisions on agreement during Delphi (Okali and Pawlowski, 2004; Holey et al., 2007), we (statistical expert and me) decided not to include the results of kappa in the final analysis for the reason mentioned above. Hence, the final decisions were based on Wilcoxon and McNemar results instead.

For the ranking, the following was undertaken:

Computing the average and median rank for each question (within each subsection), similar to the process performed for the rating and following the same rationale and recommendations in the literature;

Ranking questions based on average and median rank (within each subsection).
Questions that were ranked in the lowest 20% were removed, as suggested by Okali and Pawlowski (2004), and thus, 10 to 12 EBQ and PBQ were retained for each principle. Only 10 experts out of the 15 performed the rating and ranking for all the sections they were asked to review. However, 14 did undertake ranking, and the results demonstrated agreement with the rating conducted in Round 3. This provided a clear indication of the questions that received the lowest ranking and thus were dropped from the tool. Table 12 below presents the total number of questions before and after the Round 3 consultation. It also presents the decrease in the number of questions across the five principles of the tool following each of the three rounds of consultations.

Table 12: Number of Questions across the Five Principles and the Sections of the Tool after the Three Rounds of Consultations

Sections	**Initial Number of Questions before Round 1**		**Number of Questions before Round 2**		**Number of Questions before Round 3**		**Number of Questions after Round 3**	
	EBQ	**PBQ**	**EBQ**	**PBQ**	**EBQ**	**PBQ**	**EBQ**	**PBQ**
Participation	23	15	20	17	15	11	12	9
Transparency	19	11	14	12	10	10	10	9
Accountability	14	16	13	13	11	10	12	9
Information	18	13	12	12	13	10	12	9
Responsiveness	15	14	16	12	14	11	12	9
Total	**89**	**69**	**75**	**66**	**63**	**52**	**58**	**45**

4.7 Effect of the Delphi Process on the Tool

The effect of the Delphi consultations on the tool was mainly on the content, coherence, and the structure. The general comments have been summarised in Table 9. The specific comments primarily concerned clarity and practicality in addition to the inclusion of new concepts. The three rounds of consultations with at least 15 governance experts (Round 3) resulted in the following: concepts that were retained are all based on Table 3 (from chapter three), extracted from the literature review; almost all the concepts identified from the literature were included in the tool whether as EBQs or PBQs . The questions that were removed were either duplicates or concepts difficult to assess (see Table 7). Concepts that were added in the final tool have been summarised in Table 8.

See Table 13 below for examples of how questions evolved before and after the three rounds of Delphi consultations to visualise the significance of the change in refining the tool's content.

As for responsiveness, the final draft of the tool after the three rounds of Delphi consultations suggests that any health policy should comprise the domains of responsiveness as defined by the WHO (discussed in Chapter Three) in the form of goals/objectives, and these are as follows:

- Ensuring access to adequate quality of services for all;
- Respect for confidentiality and dignity of the beneficiaries;
- Health providers/health institutions should respect the autonomy to participate in health related decisions, freedom of choice of care provider, and provide all information related to medical conditions in an understandable manner;
- Health/public health services should be provided within a reasonable timeframe;
- Needs assessment targeting the public should constitute an integral part of the policy formulation process, whereby policies should be formulated based on the people's to ensure that their rights and needs will be addressed in their implementation;
- The monitoring and evaluation of a given policy should contain a component to assess whether the policy fulfils the population's needs.

Table 13: Examples of Questions before and after the Delphi Process across the Five Principles

	Before Delphi	After Delphi
Participation	Are the following stakeholders represented in the policy formulation that is concerned with … ? • State actors (government): Specify: Health service providers (professionals and organisations): Specify: • Beneficiaries and/or public: Specify: • Civil society: Specify: • Media • Others: Specify:	Were the following stakeholders represented in the formulation that was concerned with the national health strategy? (select all answers that apply by adding a √) • State actors (government, other than MoHs, national, local): Specify: • Health service providers (professional association/unions/orders and health service organisations/hospital boards (public or private)): Specify: • Parliamentary members • Beneficiaries (patient associations) and/or public: Specify: • Civil society: Specify: • Development partners/international organisations: Specify: • Funders/financiers: Specify • Academic institutions/researchers: Specify: • Private sector (medical, pharmaceutical industry, insurance companies): Specify: • Most vulnerable or key affected populations: Specify: • Media • Others: Specify:
Accountability	Is there a formal mechanism to hold the participants/stakeholders in the policy formulation related to … accountable? Y/N	Is there a formal mechanism(s) to hold stakeholders (public officials and non-state actors) in the policy formulation related to the national health strategy accountable (for decision and policies formed): Y/N • To their institutions/organisations • To the Public
Transparency	Is the MoH transparent in the policymaking process? How?	Was the policy formulation process of the national health strategy perceived as transparent by stakeholders? By the public? What made it transparent? What could have been done to make it more transparent?
Information	Was enough evidence used in the formulation of the policy? What type of evidence was used?	What type of evidence was used in the formulation of the national health strategy? Do you consider the evidence used pertinent/adequate? Why? What additional evidence would have been necessary?
Responsiveness	Does the policy document relating to ... mention that it will not impose any discrimination? Y/N	Does the national health strategy document provide for/ensure that it will be inclusive of all the population/patients? If yes, does it identify specific disadvantaged/vulnerable groups to be included? Specify:

4.8 Validity Testing as Part of the Delphi Process

The Delphi method ensured content as well as construct validation of the tool developed (Okali and Pawlowski, 2004). Content validation was achieved by gaining consensus on the characteristics of governance principles identified based on theoretical definitions covered within the tool (Trochim, 2006). The experts were asked to double check whether the questions in the tool captured all aspects of the principles to be assessed. The involvement of knowledgeable and interested experts in the Delphi process maximised the content validity of the tool (Hassoun et al., 2000).

With regard to construct validity, it was achieved by asking experts to validate the researcher's categorisation of the main aspects derived from the literature for assessment under each of the five principles. In addition, it was achieved by asking the experts to validate their own responses, which contributed to consistency of understanding of the governance principles (Okali and Pawlowski, 2004). Furthermore, construct validity was achieved by experts' contribution to the generation of new concepts (that were not found in the literature review) to be included in the tool and the reprioritization of questions to be retained.

Face validity was determined by considering the list of questions as a whole and determining whether they made sense and what they should assess in terms of governance principles and their role in the health policymaking process (Trochim, 2006). Finally, concurrent validity was also increased with the three successive and successful rounds of consultations (Hassoun et al., 2000).

4.9 Commitment, Attrition, and Key Factors in the Success of the Delphi Consultation

Experts' commitment to be involved in Delphi consultations was a key factor in its success (Hasson et al., 2000). The commitment is related to their interest in the subject under study (Hasson et al., 2000), and all the experts who were involved in the Delphi process exhibited a high degree of interest in contributing to the content of the tool to assess health governance.

- 14 experts (out of 25) were involved in the three rounds of consultations (56%)
- 5 were involved in two rounds (20%)
- 6 were involved in only one (24%).

The majority of the experts sent their comments on time, despite delays caused by a few. Attrition refers to experts' dropouts/withdrawal from the Delphi consultation (Okali and Pawlowski, 2004) (see Table 14 for attrition rate across the three rounds of consultations).

Table 14: Attrition Rate Through the Three Rounds of Consultations

Delphi Rounds	Total Number of Experts Consulted	Total Number of Responders (%)	Attrition Rate
Round One	30	22 (73%)	27%
Round Two	25*	21 (84%)	16%
Round Three	20**	15 (75%)	25%

*3 newcomers, ** one expert asked to withdraw from Round 3

The Delphi consultation has the potential to generate low response rates due to the fact that multiple rounds of consultations are needed (Hsu and Sandford, 2007). A total of 60% of experts at the end of consultations presents an extremely good figure, given the extensive review required in each round; further, it also signifies a high level of commitment.

Other key factors that contributed to the success of Delphi process in this research, consistent with what is mentioned in the literature includes the following:

1. Selection of appropriate experts (Hsu and Sandford, 2007);
2. It is important to be referred by someone (gatekeeper) in the process of recruiting experts (Hasson et al., 2000);
3. Administrative skills (Okali and Pawlowski, 2004), using a coding system for responses of experts and across the three rounds, following up with experts, managing and analysing responses (with the help of statistical experts);
4. Maintaining a diary that included all details related to Delphi, from planning to implementation of the three rounds for proper planning, management, and reflection.
5. Use of emails as a method of communication and Skype calls when there was a need to facilitate the Delphi consultation (Hsu and Sandford, 2007).

4.10 Reflecting on the Delphi

In general, the comments of Delphi experts led to improvement in the way the questions were framed, the merging of several questions, and addition of filter questions and sub-questions. In addition, new questions were added and others were removed.

Most of the comments were reflected in draft 2 and draft 3 of the tool. Comments that were not addressed were highlighted, and explanations were provided as to why they were not addressed. I assumed a neutral position to the degree possible to the experts' comments to reduce the possible bias from my own interpretations to the application and practise of HSG.

The generation of descriptive statistics for this research enabled gaining an oversight of the data and the patterns of the overall responses. This further aided in minimizing any tendency to privilege responses possibly indicative of the main researcher's (myself) preferences by contributing to a reduction in the subjectivity involved in making decisions regarding the retention or removal of questions (Holey et al., 2007).

Every single comment was extremely important to highlight the strengths and weaknesses of the tool and gaps that needed to be addressed. The experts offered guidance to anticipate problems/concerns that could have emerged in conducting the tool. Therefore, I was able to provide a practical approach regarding overcoming these concerns during the pilot testing and in the manual, which was developed to help future assessors apply and conduct the tool. Most of the criticisms given on the tool were expected as the experts were highlighting the limitations of the tool, and some were useful in enhancing the tool's design and minimising these limitations. Reflecting and addressing the comments proved to be a learning experience that was enriching.

The experts in the Delphi constituted a heterogeneous group of individuals working in international development organizations, academia, public sector, and civil society, with experience, from high to LMICs. This resulted in the inclusion of different perspectives concerning HSG, the way in which it is practiced, how it ideally should be, and how they would like to see it implemented. Reaching a consensus in such a heterogeneous group on a complex subject was considered a positive indicator for producing a robust and a useful tool, waiting to be applied to test its practicality (see next chapter of pilot).

See Figure 3 for summary of the three rounds of Delphi.

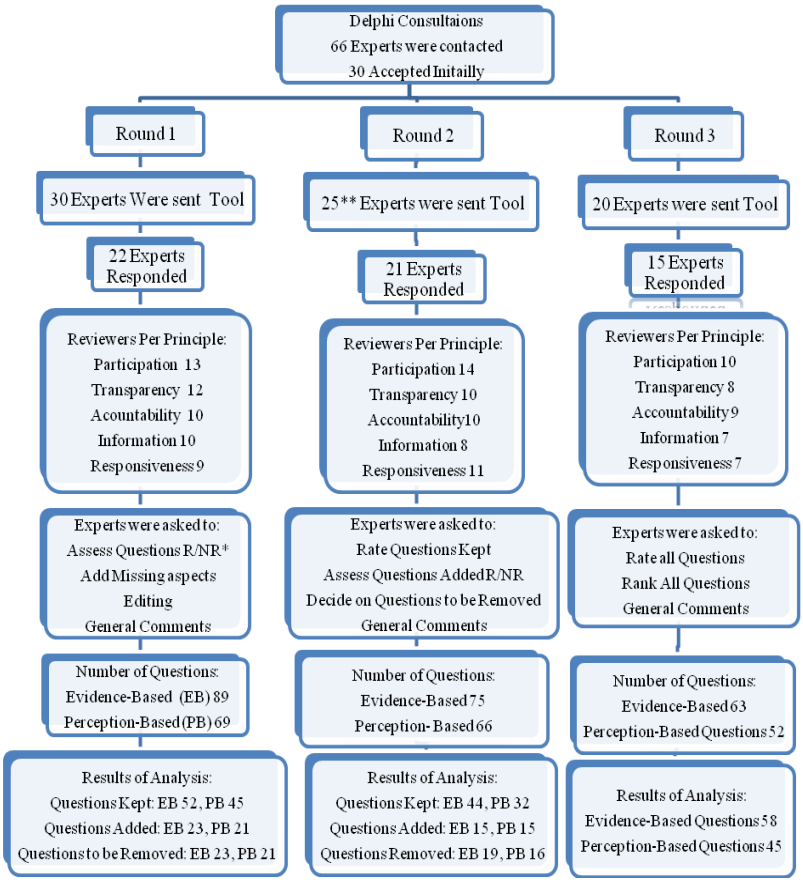

Figure 3: Summary of the Three Rounds of the Delphi Process

* Relevant/Not Relevant
** 3 New Comers

The following section will describe the consultation meeting with high-level policymakers and their contribution in further refining the tool.

4.11 Refinement Review: Consultation Meeting with Policymakers

This section covers the consultation meeting that took place with policymakers after the Delphi consultation. It discusses the benefit of having the policymakers' feedback regarding the tool in terms of its practicality, applicability, as well as usefulness for practice. It was important to obtain the policymakers' feedback on the tool (before it was finalised) as they will be its end users. Furthermore, it was essential for the tool's development in order to determine its value in facilitating the improvement of their governance practices at the policymaking level.

Conducting the Delphi consultations with experts over several rounds followed by a face-to-face panel meeting for further discussion is recommended for newly developed assessment tools, and this is termed as the RAND method, a systematic method to assure the tool's quality (Campbell et al., 2003). Moreover, it was deemed beneficial to combine the perspective of governance experts as well as policymakers to have "an agreed upon" tool for use. In the original research design, the consultation meeting was planned after the pilot testing as a final mode to obtain feedback on the tool. This was modified due to the time constraints of the funds received from the WHO to cover the cost of the consultation meeting.

- *Funding the Consultation Meeting*

I applied for funding to the WHO in consultation with the leading expert at WHO, Dr. Sameen Siddiqi (who developed a tool to assess governance and on which this work was founded; he is a Delphi expert as well), to cover the consultation meeting, and it was approved due to the importance of the topic for the WHO EMRO office. They were focusing on finding practical ways to assess and improve HSG at the country level. The one-day consultation meeting took place in December 2015 in Lebanon, right before the pilot test as the funding was earmarked for spending during 2015.

4.11.1 Selection of Participants

The plan was to invite high-level policymakers since they will be the end-users of a tool of this kind. Since funding was obtained from the WHO EMRO office, it was considered appropriate to invite policymakers from the region. In addition, I was planning to invite some of the Delphi experts, if the available funding was sufficient. The contact with Dr. Siddiqi facilitated compiling a list of high-level policymakers from the region, who were known to have an interest in improving HSG and may have been looking to conducting similar assessments in their countries. The suggested invitees were from Iraq, Iran, Jordan, Egypt, Palestine, Lebanon, Pakistan, and Morocco (not an EMRO country).

All participants were invited by email to the meeting, and all accepted the invitation except one. It was important to have a gatekeeper (Dr. Siddiqi) to recruit the policymakers to attend such a meeting, for the same as with Delphi experts, as it makes experts/policymakers more responsive towards participation. Two Delphi experts from Lebanon were also invited (since their participation did not impose any additional cost). The meeting was moderated by an academician who was also interested in HSG, and a

note keeper attended the meeting as well. My academic supervisor and a WHO Geneva staff who works on governance joined the meeting via Skype (see Annex 5 for the list of participants). So, there were in total seven policymakers from seven countries. Among the policymakers, there were two former ministers of health, and one of them is currently a parliamentary member, one an acting minister, and two were general directors, in addition to Dr. Siddiqi and another WHO former expert on governance. The participation of senior policymakers with diversity in terms of the contexts they belonged to, institutional roles (some were in political roles while others were in policymaking roles), type of experience, and interest in health governance, made the review process a valuable one. They considered the tool from the perspective of the need to have a practical tool that might favourably impact the policy process.

4.11.2 Objectives and Outcomes of the Meeting

The objectives of meeting were as follows:

- Review the content and the design of the tool;
- Discuss the operational aspects of implementing/conducting the tool in different countries;
- Discuss the most appropriate way for data presentation of the tool's findings. This was the most important aspect of the meeting as it was essential to obtain policymakers' feedback concerning their preferred way of receiving the results in a meaningful way, so that they can act upon them, given the tight schedule to review detailed assessment reports.

These objectives were set with the following aims:

- Finalise the tool to be ready for pilot testing;
- Provide feedback on the presentation of the results.

To facilitate the review process, the tool was sent by email to participants two weeks prior to the meeting.

The feedback received during the meeting was categorised into the following:

- Methodology and process for conducting the tool;
- Content and structure;
- Analysis and presentation of the results.

As an outcome of the meeting, the following changes were made:

- *Methodology*

1. Desk review and KI interviews: The policymakers advised that the methodology of collecting the data for the EBQs should be changed to interviews with KIs supported by a desk review, as, in their view, only the latter would be insufficient. It might be difficult to find documentation for the work of MoHs/health authority in LMICs. Thus, depending only on document reviews for data collection data would pose the risk of having incomplete information, which may not reflect reality (OECD, 2005). Hence, I decided to conduct a desk review first, followed by interviews with KIs, and during the latter, the KIs would be asked whether they could provide any kind of documents to support their responses. Furthermore, it should also be noted that this concern regarding the applicability of data collection through the desk review only was raised earlier as well by some of the Delphi experts; but, it was not addressed at that point.
2. Data collection for the PBQs was retained as it was, which implies that both sections (A and B) of the tool would involve face-to-face interviews. Thus, the tool should be conducted as a series of steps, including the desk review of all relevant documents, followed by two sets of interviews (one to cover the EBQs, Section A, and the other to cover the PBQs, Section B). The decision to include two sets of interviews with KIs was based on the length of the tool and the time required to conduct it, which was also done by Baez-Camargo and Jacobs (2011). It was decided to retain the long list of questions for the pilot testing due to the significance of the components to be assessed.
3. KIs: These should be selected because they have been involved in the policymaking process. They could be the policy formulation technical team within the MoH, policymakers, and/or the other stakeholders, including the private sector. Their number will depend on the policy type (whether it is broad or specific, number of stakeholders that will be affected, among other things), its complexity, the characteristics of the policy, and how many groups or organisations were involved in

the formulation process. However, the policymakers suggested KIs between 8 to 25 would be reasonable. Therefore, my target KIs for the pilot was within this range.

4. Endorsement and who should conduct the tool: Since the tool is intended to be used by policymakers to cover a "sensitive and complex" issue, it was important to decide who should be entrusted with conducting the tool at the country level to ensure the implementation of the recommendations that will result from doing so. The policymakers agreed that the tool should be endorsed by the MoH and should be conducted under the supervision of senior staff to ensure ownership, and consequently, better implementation of the recommendations generated from its application. It could be conducted by a team from within the MoH, the team could be junior staff, but they should be working under the supervision and the guidance of senior staff. Alternatively, the MoH could nominate an external expert (from academia, for example) to conduct the tool; but, again, it should be conducted in collaboration with senior staff at the ministry to ensure ownership and commitment to implement the recommendations. It will be pointless to conduct the tool by academia or any other independent researcher without an endorsement by MoH, in which case, it would not serve its purpose, which is improving practices and not only assessing it. I agreed with this recommendation in light of the problems that might arise from this approach. For example, the review could be politically inflicted, especially in hierarchical systems, where KIs might be concerned with providing the "right" answer, or when KIs might try to defend their practices or conceal relevant information for different reasons. This is another reason due to which it is important to conduct a desk review of available documents before conducting the interviews as well as asking KIs to provide evidence when available, which can be documented in the final report of the assessment. In addition, the triangulation of the responses of different KIs is recommended in the analysis of the results. The endorsement of a senior official or a political will to improve the governance practices would be helpful in implementing the recommendations of the assessment in practice.

   Donor organisations could also conduct the assessment tool as a prerequisite for funding as GG in policy process is attractive to donors (Pyone et al., 2017). If they do so, they should emphasise the significance of providing evidence of GG practices by KIs to support their responses as well as to hold policymakers accountable for their claims for having such processes in place.

5. It was also recommended that an orientation meeting be conducted with the MoH before the assessment to help locate the required documents for the desk review and

to identify other stakeholders who could be contacted as potential KIs. Finally, it was agreed that the tool would be implemented retrospectively and applied to newly developed policies (within a year).

- *Content and Structure*

In general, the feedback on the content pertained to wording, ambiguity, and sequence. It was suggested that the list of PBQs be shortened, in particular, because some overlapped with the EBQs. One recommendation regarding the content was to place the accountability questions before the transparency ones to allow improved consistency and flow. One question concerning the rule of law was added to the accountability section. The majority of the policymakers agreed that it was important to retain the responsiveness section due to its importance as it highlights the components that require to be included in any health policy, if it is to be responsive to the needs of the population. Assessing the responsiveness section might generate useful recommendations reflecting on the importance of having patient-centred policies as a part of being responsive. They agreed upon domains of responsiveness for assessment as part of the goals of any health policy (discussed in Chapter Three) and welcomed the additions that the Delphi experts had added (as discussed in chapter four). In addition, the policymakers suggested to add to responsiveness characteristics; that policies should include an explicit package of benefits that will be provided as it is the right of the public/patients to know their rights and responsibilities, which should be clearly stated in any health policy (when applicable). This will reflect on the health system's responsiveness.

Also, they suggested adding information about the way in which the referral will take place from one level of the healthcare system to the others, so the public is aware of what they will be eligible for and what to expect in terms of referring their medical cases from one level to another and how this referral will take place within the stated time frame for this referral. These should be clearly stated, which would again form a sign of the health system's responsiveness.

It was also recommended that the questions concerning the inclusion of an official complaints mechanism be moved from the accountability section to the responsiveness section as being responsive to the needs of people entails having such a mechanism in place to enable public to report any violation or raise concerns regarding the services provided to them. In order to encourage people to employ such mechanisms, it is crucial to ensure follow up on the complaints reported. Moreover, the investigation on complaints should be conducted in a timely manner, and the results should be published (actions and

justifications). Also, they suggested moving the question about having a communication strategy in place to inform the public regarding national policies from the transparency section as communication is a component of responsiveness (Darby et al., 2000). A communication strategy is essential to ensure that information is freely available and directly accessible to the public. It should also be the case that sufficient information is provided in an easily understandable form and with a suitable channel of communication. I agreed with the proposed additions and shifting of questions to the responsiveness section.

The policymakers also suggested extending the answer options of the EBQ to include "Yes", "No", "In process", "Don't know", and "Not applicable". I agreed with this suggestion as well as some processes might be in progress or not finalised yet, and some KIs may not be aware about certain process, and some questions might not be applicable in some contexts, making this a logical suggestion.

Before the consultation meeting, the number of EBQs and PBQs was 58 and 45 respectively, which was reduced to 52 and 36. The decrease in the number of questions was less as a result of the consultation meeting in comparison to the individual rounds of the Delphi process. Again, this demonstrates that policymakers did not suggest considerable changes in the content; their main contribution was to adjust the methodology for conducting the tool and its structure. This made it a more practical, user-friendly, and therefore effective tool in terms of highlighting key aspects of GG of policymaking process.

- *Presentation of Results*

It was decided that scoring would not be used. All the participants agreed that scoring would be difficult as it would be used to compare and rank countries, which would not be appropriate as different countries have different health systems, political systems, and face different instabilities, all of which affect the governance of the health system and the policymaking process. Furthermore, scoring questions would require giving different weighing to different questions, and this was not possible at this point of the tool's development. In conclusion, it was agreed that scores would not be used to report the findings of the tool.

Instead, it was agreed that various formats would be employed to present the findings in a useful way for policymakers and the MoH/health authorities. This is consistent with Kettl's (2016) recommendation, making "data speak in a language that policymakers can hear" by using graphics and summaries (Kettl, 2016, p.578). Thus, it was decided that the final

presentation of the findings will be in the form of a strengths, weaknesses, opportunities, and threats (SWOT) analysis, traffic lights symbol summary, and a list of recommendations covering the five principles to enhance their practise at the policymaking level. The traffic lights summary was utilised by the WHO to present summary findings of the pharmaceutical sector's profile to policymakers (WHO, 2014) in a simple and attractive format. Red was used for processes, practices, structures, documents, and policies that did not exist, while green was used to indicate that they exist and function well and effectively. Lastly, yellow suggested that work was in progress or ongoing.

It was suggested that a manual be included to enable the tool's application for future users. Finally, it was decided that the tool would be called a guidance tool and not an assessment tool since the end-users of the tool will be policymakers, and they will be cognisant of the concepts covered and their importance in contributing to GG in policymaking. Furthermore, the tool might initiate wider reflections by policymakers and stakeholders regarding the recommendations produced by using the tool. The expected outcome of conducting the tool is to focus on improvement based on the results rather than judging or rankings of countries. The nature of this guidance nature was implied in the importance of assessing HSG, as discussed in Chapter One, and in the scope and the purpose of the tool, mentioned in Chapter Two.

- *General Feedback*

All the participants in the consultation meeting emphasised the importance of HSG in general and at the policymaking level in particular. It was agreed that there is a global gap in knowledge as well as a lack of tools to assess the situation in different countries and that the time was opportune to expand by building on previous work. Some participants praised this research as a step towards closing some of the existing gaps. They emphasised that tools (like the one presented during the meeting) should not be an end in themselves and that guidance should be provided to countries regarding ways to improve the quality of governance, taking into account the political context, specificity of each country, and other factors. The adjusted tool was sent to three policymakers after the meeting (among the ones who attended), and they were asked to provide final feedback regarding the adjustments made. All three who were sent the adjusted draft of the tool apologised for not having time to review the tool again and said they trusted the changes made. This indicates the reason due to which it is better to consult high-level policymakers through face-to-face meetings.

4.12 Reflection on the Consultation Meeting

The process that was followed during the consultation meeting to review the tool to meet the objectives of the meeting was essential for its success, given the short span of time that was given to discuss various essential issues. Another critical factor that contributed to the success of the consultation meeting was the selection, quality, and interest of the policymakers who participated. Face-to-face discussions carry the advantage of creating room to discuss more issues, not being limited to focussing on questions asked to the participants for feedback. This was unlike the Delphi consultations, in which the experts responded to the specific questions they were asked regarding the tool. The policymakers' advice regarding the methodology (with regard to conducting interviews with KIs combined with desk reviews) was extremely helpful as they offered practical and logical advice based on their experience in the context of their countries (all LMICs) and was consistent with some of the concerns raised during the Delphi consultation about having a desk review as the only source to collect data for the EBQ. In addition, the meeting led to gaining feedback regarding ways to present the findings of the tool in a useful way to busy policymakers. In conclusion, their contributions were helpful in refining the tool further before the pilot test.

In sum, to the extent of my knowledge, the proposed tool is the first health governance assessment/guidance tool to be developed and validated by the Delphi process. This process was particularly appropriate because health governance remains a vague concept that requires operationalisation of theories as well as experts consensus regarding what constitutes good governance practices. Hasson et al. (2000, p.1013) stated that "several people are less likely to arrive at a wrong decision than a single individual". This research and the tool involved starting a highly useful dialogue amongst experts in the field that enriched their understanding regarding HSG. The consultation review by a group of high-level policymakers from different countries, who reviewed the tool from the perspective of the end-user, offering an extremely insightful direction regarding aspects that might be applicable and those that might not be in real life settings. Furthermore, they offered advise concerning on ways to conduct the tool to generate useful information and present the findings to attract policymakers' attention. The purpose of the consultation meeting was to offer feedback regarding the usefulness, practicality, and feasibility of the tool, while the Delphi process's purpose was to further develop the conceptual content of the initial tool, in order to test its validity. Both of these steps were essential before it was pilot tested.

Combining the perspectives of policymakers with those of the Delphi/governance experts resulted in taking a step further with regard to our understanding of HSG.

The tool was build on a rigorously robust academic basis and received consensus on the content by some experts in the field in addition to some policymakers from LMICs. It is hoped that the tool will receive further and broader consensus regarding its practicality and usefulness to generate relevant information.

Chapter Five

Pilot Testing and the End-Product

This chapter covers the final phase of this research. It begins with a description of the process followed for the tool's pilot testing in a real setting, which should be replicated whenever the tool is used in other settings. The chapter also includes the method followed for the analysis, a presentation of the results obtained, recommendations emerged, and the way in which the pilot led to the further refinement of the tool. The chapter concludes with a description of the end-product: the tool and its manual.

5.1 Pilot Testing

After adjusting the tool based on the feedback received from the policymakers and the other experts during the consultation meeting, it was deemed ready for field testing. Pilot testing constituted an important step in the development of this new guidance tool (as labelled by the policymakers). The pilot testing of the final draft of the tool was planned to assess its feasibility in practice in terms of consistency, ease and speed of data collection, among other factors (Campbell et al., 2003). Other factors such as acceptability of the questions was also considered in the piloting phase (Campbell et al., 2003, p.818).

5.1.1 Pilot Testing Process

- *Setting*

The pilot testing was conducted in Lebanon for practical reasons (since I reside and work there). In addition, Lebanon is classified as a middle-income developing country, and as mentioned earlier, the tool was developed to be used specifically in LMICs, where it is believed it would be most useful due to the lack of governance in these countries (as discussed in Chapter Two). With regard to this, it has been asserted that in Lebanon, among the top five most problematic factors for development in general (with implications for the health sector) are corruption, inefficient government bureaucracy, and policy instability (World Economic Forum, 2016). Thus, improving GG in all sectors and at all levels should facilitate the achievement of the developmental goals (Pyone et al., 2017).

- *Policy Type*

The tool is generic in nature as it was designed to be sufficiently flexible to analyse the governance processes of the policymaking of any kind of health policy. The experts and the policymakers agreed that the policy process to be evaluated should be related to a recently formulated and implemented national policy/strategy in a country within the previous year. The mental health strategy for Lebanon (2015–2020) was selected as it was developed nine months before the pilot phase. It also seemed an appropriate option for the pilot as it forms a specific type of health policy and is not too broad, with a limited number of stakeholders. However, the tool can be employed with other broader types of policy such as human resources policy or the strategy on non-communicable diseases (NCD).

- *Study Design*

The pilot testing included two parts: desk-review and KI interviews based on the tool. The data collection started with a general desk review to compile background material and data collection from various documents in order to gain a clear understanding of the strategy developed and the mental health issues, in specific, in Lebanon as well as to acquire a general perception of the health system to comprehend the context. The second part of the pilot included face-to-face interviews with KIs using the developed tool.

- *Study Procedures*

1. Desk Review of Documents

The following documents were reviewed:

- Mental health strategy (2015–2020) in both languages, English and Arabic;
- Relevant laws and policies related to mental health in Lebanon;
- Health statistics concerning mental health;
- Media reports;
- Newsletters and patient leaflets developed and published by the mental health programme;
- Scientific publications regarding mental health in Lebanon;
- Relevant laws and regulations pertaining to drafting national policies in general and publishing them.
- The ministry of health's official website was reviewed extensively as well.

During the review of the documents, I was looking for the authors (to reflect on the credibility and the reliability of the source), the organisation responsible for issuing the document, whether the MoH or another agency (to consider whether it is an official document, academic research, and so on), date of issue (to consider whether it was up to

date), whether the document was published or unpublished (to assess its availability), and whether it can be found in one place, such as a website, department, and so on (to assess if it is accessible or not). I also looked for references, considered ease of access, and considered the language of the available documents. I was mainly searching for answers to the questions in the tool, and I did that by going back and forth to different sections within the tool. I identified all the documents initially reviewed by searching for published documents as well as the MoH websites for additional ones. The initial document review process took around three weeks. The document review process was important before conducting the KI interviews as it can offer insights regarding issues related to the policy under study and the relevant stakeholders. This will be of value for assessors who use the tool and review a policy domain that they are familiar with as well as for assessors unfamiliar with the policy or the national context. The primary challenge with the document review was ensuring that all relevant documents are identified, to avoid missing out any important ones; the mental health team were asked for guidance during the orientation meeting (see below); the KIs were also consulted during the interviews for relevant documents to compile the maximum number of useful sources. The only way to ensure that the results extracted from the documents are reliable was to compare them with the responses of KIs. In case of contradictory findings, further investigation would have been required, either with the national team, the KIs themselves, or interviews would be needed with more KIs. During the pilot, I did not come across any contradictory information between the document review and the responses generated by the interviews with the KIs.

2. Orientation Meeting with the National Team

A preparatory meeting was conducted with the mental health program team to inform them about the pilot, the purpose of the tool, how the pilot would be conducted, and to ask for their help to conduct a mapping of all stakeholders, who were involved in the formulation process of the strategy. The mental health team provided a list of names of relevant stakeholders along with their contact details. To avoid the risk of leaving relevant stakeholders out of the list (whether intentionally, due to the concern that they will not offer positive feedback, or unintentionally), the list of the relevant stakeholders was verified with the KIs, who accepted to be interviewed, and from the document review that was initially undertaken.

Thus, purposeful sampling was employed to ensure the selection of "information rich" KIs using what is termed as snowball or chain sampling (Patton, 1990). The KIs identified

were deemed knowledgeable about the policy formulation of the mental health strategy of Lebanon and were directly involved. These KIs included official staff from the mental health programme as well as representatives of various organisations. During the consultation meeting for constructing the tool, it was advised that only those stakeholders be included who were involved in the process of developing the policy as those excluded from the formulation process (whether intentionally or unintentionally) would not contribute a useful perspective. This implies that KIs who were not involved would not be able to identify the process's strengths and weaknesses.

3. Approaching Potential KIs

The list that was provided by the national team and included eight categories of stakeholders, who were involved, and these have been summarised in Table 15 below. The list included 23 names (some from the same organisation); so, I contacted a total of 20 potential KIs (I contacted one from each organisation, except for the mental health programme team), and all were contacted by email with an invitation to participate in the pilot. The KIs were informed that the national mental health programme was informed about the assessment and their names were suggested by the programme. This was done with the view that policymakers at the consultation meeting were aware of the significance of the political "buy-in" and "ownership", which was believed to increase the number of KIs willing to be interviewed. It was further believed that if the senior leadership's interest in enhancing the governance of the health policymaking process is publicised, more KIs will be encouraged to participate.

Out of the 20 KIs contacted, 11 responded positively to the invitation, a response rate of 55%, and all those who agreed participated in the pilot. The original plan was to have a sample size of 10 to 15 KIs for interviewing.

Table 15: Summary of KIs Identified, Contacted and Agreed to be Interviewed

Key Informant Group	Number of Organisations Represented	Number Contacted	Number that Agreed to be Interviewed
UN Agencies	2	2	2
Local NGOs	2	2	1
International NGOs	3	3	1
Universities	5	3	2
Professional Associations	3	2	1
Mental Health Units and Hospitals	2	2	1
Governmental Agencies Other than MoH	2	2	0
Mental Health Program Team-MoH	1	4	3
Total		**20**	**11**

The email included a brief about the research and the tool, what the pilot would include, and what was required from KIs (see Annex 8, Manual Annex for information sheet sent to KIs). The consent form was attached to be signed and returned by email by those who agreed to participate. Those who did so were asked to set an interview time at a place that suited them. Furthermore, in the email, the potential KIs were informed that two interviews would be conducted with them. The first would be conducted to collect data related to EBQ using a structured questionnaire, in which they would be asked to provide evidence and documents to validate their responses whenever possible. The second interview would be conducted to collect data for PBQ, also via face-to-face semi-structured interviews as this would allow the generation of in-depth information regarding the process followed in of mental health strategy development.

The KIs were informed that each interview might require around 50 minutes, and they were given the option to have one interview to cover both sets of questions. May (1991) reported that the length of the interviews varies depending on the topic, researcher, and participant, and usually, interviews with professionals can last for up to 60 minutes. However, longer interviews can be conducted on more than one occasion (Gill, Steward, Treasure and Chadwick, 2008), while others suggest that interviews that last from 50 to 90 minutes are acceptable (Choi and Oak, 2005).

The reasons for including two interviews for each KI were as follows; first, the time needed to conduct the two sections (A and B) of the tool; the second reason was to allow assessors more time to read and analyse the documents provided during the first interview.

The time lapse suggested between the two interviews was set to be one to two weeks at the most. The intervening time between the two interviews actually offered both the assessor and KIs opportunities to reflect and contribute to the learning from the tool. This was highlighted by some of the participants at the end of the interviews (as discussed below under the KIs feedback section). Baez-Camargo and Jacobs (2011) also suggested using two rounds of interviews for the assessment they developed on health governance in low income countries.

4. Interviews Conducted with KIs

As mentioned above, 11 KIs were interviewed (see Table 15). The only category that was not included in the pilot sample was other governmental agencies (such as the Ministry of Social Affairs and the Ministry of Justice) since all potential KIs contacted did not respond to the invitation email. This may be because it is difficult to recruit this category by email or they do not have the time, are not interested in the topic, or are simply unaware of the topic and its significance.

Out of the 11 KIs,

- three (27.3%) decided to have the two sets of interviews in one session;
- five (45.4) opted for two different times for the interviews;
- three (27.3%) refused to do the second interview (one said they had nothing else to offer and the other cited a tight schedule as the reason).

Hence, 11 KIs answered the EBQ, while only eight answered the PBQ. All of the KIs were engaged in the interviews for more than 45minutes. This could be due to their interest in the topic (as it is reflected in their responses when asked about their feedback on the tool, discussed below). In total, 16 interviews were conducted to cover the two sets of questions between the beginning of March and end of April 2016. The KIs were asked to sign an informed consent sheet before starting the interviews in cases in which this was not done by email (see Manual Annex 8 Consent form). They were assured of the confidentiality and anonymity of their answers. All questions were asked in relation to the aforementioned mental health strategy that had been recently developed. For each KI, a questionnaire was coded and their answers and notes were recorded during interviews. They were asked for permission to tape record the interviews even with the EBQ and were given a chance to elaborate their answers and explain the policy formulation process in detail.

Thematic saturation, that is, having no further useful information from KIs (Guest, Bunce and Johnson, 2006), was reached with KI number 7; however, I continued the recruitment

process as the target was to include all categories of the stakeholders in the pilot to ensure the collection of as much perspective as possible, and this could be reached by including a diverse set of KIs (see Table 15 of KIs who were interviewed).

5.1.2 Analysis of the Pilot Findings

After each interview, the responses were entered into Microsoft Office Excel for the EBQ, while transcriptions were prepared for the PBQs, with notes recorded on a separate sheet. In addition, observations and comments regarding the tool itself and the various questions were recorded for the final adjustment of the tool.

The data were entered onto an Excel sheet and analysed, and I generated the descriptive statistics (which merely entailed a simple counting of the responses Yes, No, Don't Know, In Process, Not Applicable) as the sample size was small (11). Thematic content analysis was also conducted after the transcription of the interviews. This included generation of the initial ideas from the interviews, identification of common themes and concepts from the responses of KIs, followed by their categorisation, coding, and analysis (Braun et al., 2006). This was mainly done to see common themes that emerged from the interviews, mainly pertaining to challenges and factors that facilitated or obstructed the policymaking process. (see Annex 6 Summary of Results: A. Summary of Evidence-based Question Analysis and B. Summary of Perception Based Questions Analysis).

5.1.3 Results

This section presents the findings of the pilot based on the data collected and analysed from both the desk review and the KI interviews. The pilot allowed the identification of the strengths and the gaps in the mental health strategy formulation process from a governance perspective. (see Annex 6 Section C for Summary of findings per principle and according to identified characteristics).

From the findings, it can be observed that the tool could assess the extent to which the development of the Mental Health Strategy fulfilled GG principles.

The gaps that were identified across the five principles were the absence of a formal national committee or working group formed officially for the development of the strategy, no adherence to a structured process, lack of a written mandate specifying roles and

responsibilities, absence of a follow up with stakeholders regarding implementation plans, and monitoring and evaluation (M&E), absence of published minutes of meetings; furthermore, implementation plans and progress reports were not shared with all stakeholders, no clear implementation plans and roles and responsibilities were defined and beneficiaries, and parliamentary members and the media were not involved in the formulation process. Moreover, stakeholders involved in the policy formulation process did not sign a Memorandum of Understanding (MoU) before being engaged in the policymaking process, the MoH does not use formal mechanisms to hold public officials and other stakeholders accountable for their role in the policy formulation, independent audits are not conducted to ensure implementation within a set timeline to assess whether targets are reached, whistle blowing mechanisms and watchdog organisations are not encouraged, no sanctions are set in case of violations/failing to adhere to the set standards, and relevant law are not enforced. There is no regulation to allow public access to government information, resource allocations related to the strategy are not made public, there is no action/operational plan published, and no COIs were signed by the stakeholders who were involved in the policy formulation. The MoH does not validate the data sources nor check the source of funding of research, there is no specialised unit for research analysis for policymaking, financial information was not utilised for the strategy development, public opinion concerning the strategy was not sought, and progress reports regarding the strategy implementation are not disseminated to the public. The strategy does not specify an explicit benefit package for the patients, nor the way in which the referral will take place from one level of care to other, no timeframe is set to provide the services needed, and no needs assessment was conducted as part of the formulation process.

Based on the summaries of the results and the analysis, in order to prepare a useful brief of findings for policymakers (as they are usually not interested in reading detailed reports), the traffic lights symbol summary for each of the five principles (for implications see below), general SWOT analysis, and a list of recommendations were prepared and have been presented below.

Implication of Traffic Light Results

Colour Code	Meaning
	Does not exist/not practised
	Either in progress or exists, but not practised or exists, but stakeholders are not aware of it
	Exists

NB: The policymakers should work on turning the yellow and red into green as well as maintaining the green

Table 16: Traffic Lights Summary

Participation	
Legal basis/requirement (law/regulation/policy) to include various stakeholders in the health policymaking process	
A commitment to ensure some degree of stakeholder participation in formulation and implementation	
A body or mechanism(s) employed to involve stakeholders in the development of the mental health policy, working group	
Formally formulated	
A written scope/mandate for stakeholder involvement in the formulation of the mental health policy exists	
Roles and the responsibilities of participants for various stakeholders are specified	
Qualifications of the participants for various stakeholders are specified	
Timetable to perform the work	
The various stakeholders represented in the formulation of mental health policy included the following:	
State actors (government, other than the MoH, national, local)	
Health service providers	
Parliamentary members	
Beneficiaries (patient associations) and/or Public	
Civil society	
International organisations	
Funders/financiers	
Academic institutions/researchers	
Private sector (medical, pharmaceutical industry, insurance companies)	
Most vulnerable or key affected populations	
Media	
Participants involved in the formulation of mental health policy were as follows:	
Appointed	
Elected	
Representing their organisations	
Gender balance/consideration (male versus female) among the stakeholders participating was considered	
Dedicated resources made available to enable participation included the following:	
Cost of meetings (venue, coffee breaks, and printouts)	
Incentives for participants (fee or honoraria)	
Transportation (direct payment or reimbursement)	
Documentation (minutes of meetings) exists	
Minutes published/made available to the public	
Final decisions were taken by participants:	
Consensus	
Various stakeholders to be involved in the implementation of the mental health policy included:	
State actors (government)	
Health service providers	
Beneficiaries (patient associations) and/or Public	
Civil society	
Development partners	
Academic institutions/researchers	
Private sector (pharmaceutical industry, insurance companies)	
Media	

Local authorities/community-based organisations	
Roles and responsibilities of the various stakeholders in the implementation process specified	
Participatory body to oversee the implementation of the mental health policy	
Strategies used by the MOH/Health authority to encourage participation by different stakeholders in policymaking in mental health	
Opinion polls/surveys	
Focus groups	
Online platforms	
Voting	
Hotline	
Policy dialogues	

Accountability	
MoH/health authority requires signature of contracts/MoU with various stakeholders before engaging them in:	
Policy formulation	
Policy implementation	
Formal mechanism(s) followed by MoH/health authorities to hold public officials and non-state stakeholders involved in the policy formulation accountable	
Stakeholders are held accountable as:	
Institutions/organisations represented	
Individuals are represented	
Accountability types used by MoH/health authority to hold various stakeholders accountable	
Ethical	
Professional/performance	
Legal	
Financial	
MoH/health authority holds its staff accountable for implementing the mental health policy by conducting:	
Evaluation of the performance of the individual staff on an annual basis	
Administrative/performance audit of the relevant department(s) on an annual basis	
Contracts' oversight	
Various stakeholders are aware of this process/results made public	
Formal mechanism(s) to hold implementing bodies accountable in line with set timelines and targets exist	
Internal within the health sector	
External by independent bodies	
External by the public	
Various stakeholders who are aware of this process/results made public	
Components of accountability mechanism(s) used by MoH/health authority at all levels are in place and include:	
Set standards	
Investigation and answerability/justifications	
Sanctions	
Enforcement	
Rewards for performance	
Appeals	
Tools used by MoH/health authority to foster accountability include:	
Information system that generates key performance indicators	
Dissemination of information	
Participation of public/civil organisations	
Whistle blowing mechanisms	
Watchdog organisations collaboration and protection	
Performance incentives for good performance*	
Enforcement of rules and regulations**	
Appeal mechanisms	
Monitoring and evaluation (M&E) of mental health policy exists and includes**:**	
Compliance with mental health policy by professionals/private sector	
Policy outcomes in terms of health improvement, efficacy, equity, and quality	
Various stakeholders who are aware of this process/results made public	

M&E process is formal	
M&E conducted independently***	
Types of sanctions applied/might be applied to implementing bodies in case of violation/not adhering to standards set/ failure to implement	
Legal sanctions	
Regulatory/administrative sanctions	
Using media: Name and shame	
Softer sanctions	
Laws in place related to the mental health policy	
Enforced	
A plan to develop a new law****	

Transparency	
A law/mechanism that allows the general public access to government information and documents	
A law/government policy in place to promote electronic government services to improve public access to government information and services*	
Official website for the MoH/health authority	
User-friendly	
Updated on regular basis	
Access to the website open to all	
Decisions related to priority setting in relation to the mental health policy made public	
Decisions related to resource allocation regarding the mental health policy made public	
Official, up-to-date (within last five years), and detailed policy document regarding mental health policy	
Publicly available	
Easily accessible	
Available on the MoH/health authority website	
Available in the official/national language of the country	
Document related to mental health policy includes the following information:	
Background on how the policy was formulated (based on international guidelines, best practices, among other things)	
Objectives, purpose, and goals based on priority problems	
Evidence used to inform policy formulation	
Mechanisms to engage stakeholder participation	
Stakeholders (names and affiliation) who participated/consulted in policy formulation	
How decisions were made/justifications for decisions	
Other factors that influenced the policy formulation	
Body responsible for releasing or approving the policy	
Clear distribution of responsibility for implementation	
Contracting requirements for implementation if required	
Time frame for implementation	
Measurable indicators and targets**	
Plans for monitoring and evaluation	
Funding requirements/allocation	
Intended audience of the document	
Official publication(s) related to implementation of mental health policy available, such as:	
Five-year strategic plan/operational plan	
Programme/project documents	
Relevant MoH/health authority decisions	
Progress reports***	
Financial reports including how funds were generated/secured for implementation/source of funding	
Policy evaluation****	
Scientific publications	
Contracts made for implementation	
Details about recruitment made for implementing	
MoH/health authorities release information related to formulated and implemented policies in a periodic/regular manner*****	
Participants declared any conflict of interest by signing an official form	
In the policy formulation	
In the policy implementation	
A policy on conflict of interest management exists	
MoH/health authority is using or has used in the past 12 months, to inform/disseminate to stakeholders	

(including the public) about mental health policy:	
Use of mass media	
Wide scale advertisement	
Bulletins/newsletters	
Targeted personal invitations	
Contact by email, telephone, mail	
Website	
Social media	
Smart phones applications	

*Government policy in place to promote electronic government services to improve public's access to government information and services: It is a government policy to simplify procedures and improve access to services using electronic services, but stakeholders are not aware of this policy
**The strategy includes targets but not indicators
***Progress reports are not published and are shared with some and not all stakeholders
****Policy evaluations are not developed yet as it is still too early to do so
*****Stakeholders believe that the national programme is not publishing relevant information in a regular manner, although a newsletter is published every three months; but, this requires better dissemination

Information	
MoH/health authority directly involved in the following in relation to policymaking:	
Information generation	
Dissemination of health information	
Publication	
Knowledge translation to policy*	
MoH using:	
Data collection tools, specify: examples: vital registries, surveys (population, facilities, etc), health statistics	
Data management technologies, specify:	
Validation of data sources	
MoH/health authority has a form of partnership/collaboration with research centres	
MoH/health authority allocates funds in its yearly budget for research related to policy	
MoH/health authorities make raw data generated at health facilities/health service delivery level accessible to researchers	
A specialised unit/staff in the MoH/health authority to deal with research analysis for policymaking exists	
MoH/health authorities have a mechanism in place to check sources of funding of research to be used in policy	
Mental health policy was informed by scientific evidence	
The scientific evidence used in policy formulation of the mental health policy is as follows:	
Reliable and of good quality source/peer-reviewed studies	
Up to date (published in the last 5 years)	
Comprehensive	
Locally appropriate	
Easily accessible	
Global	
National	
Other types of information utilised in the policy formulation of mental health policy	
Financial information	
Governing laws	
Political direction and commitment	
Public opinion	
MoH/health authority produces periodic progress reports/M&E reports on mental health policy	
Progress reports are disseminated to the public	
Progress reports are disseminated only to stakeholders**	

The following are used to disseminate:	
Printed material; flyers	
Website	
Emails	
Objectives of progress reports	
Increase awareness	
Judge the situation/identify problems	
Provide evidence	
Assign responsibility	

*Knowledge translation to policy is not used yet, but there are plans to use it
**Progress reports are not disseminated to all stakeholders

.Responsiveness	
Mental health policy provides for/ensures that it will give access to quality services for all the population/patients including disadvantaged/vulnerable groups to be covered by the policy.	
Mental health policy provides for/ensures that the health services will respect the confidentiality and dignity of the population/patients.	
Mental health policy refers to the rights as well as the responsibilities of the patients/user clearly.*	
Mental health policy refers to the explicit benefit package to be provided to the patients at the different levels of care.	
Mental health policy provides for/ensures that health services will be provided to patients within reasonable timeframe.	
Mental Health Policy refers to how the referral of patients will take place from one level of care to the other..	
Needs assessment was conducted as part of the mental health policy formulation process	
Monitoring and evaluation plans of the mental health policy include a component to assess whether the policy is meeting the population's needs through conducting patient satisfaction surveys/exit surveys.	

*The strategy mentions the rights but not the responsibilities of the patients/users.
**There are plans to assess whether the policy is meeting the needs of the population; this emerged as a result of this assessment

The SWOT analysis below was used to highlight the strengths, weaknesses, opportunities, and threats. It should be noted that the opportunities and threats emerged mainly from the PBQ, and they represent contextual factors that affected the mental health strategy development process and might affect the implementation of the strategy. These factors were the political will, financial factors, donors' interest, cultural issues, and window of opportunity to work on mental health strategy. The strengths and the weaknesses, conversely, mainly emerged from the EBQ based on the checklists of "good practices".

Box 2: SWOT Analysis of the Findings of the Pilot

Strengths	**Weaknesses**
• There is a new national programme with a motivated team • Commitment of the MoH/national programme to coordinate with all and involve all • Leadership of the MoH and the national programme were key to success • Mental Health is now a priority for the MoH • Mental health national strategy in place and serves like a guiding roadmap • National programme started to sign MoUs with stakeholders (but not all)	• No formal national committee or working group was formed for the development of the national strategy • No structured process was followed; nothing was documented • No written mandate that specifies roles and responsibilities • No follow up was conducted with stakeholders regarding implementation plans and M&E • Minutes of meetings, implementation plans, and progress reports are not shared with all stakeholders • No clear implementation plans, and roles and responsibilities are not defined • Beneficiaries, parliamentary members, and media were not involved • Public is not informed • Need to set various components of accountability: setting standards, having sanctions, enforcement, among other things
Opportunities	**Challenges**
• Availability of funding by donors • All stakeholders are motivated to be involved • Political commitment positively influenced the strategy to include all people not just Lebanese and vulnerable groups; plans to encourage the establishment of patient support groups • Technical support provided by international agencies as well as international and local experts	• Sustainability once the funds are over • Strategic planning of next steps and resource mobilisation • Accountability is a cultural issue that is related to what is right and wrong and remains a vague concept • Need to pass the amendments on the current law and enforcement • Receiving funding from the government • Governance requires institutional capacity, appropriate structure, and financial resources

The EBQ within the tool enabled identifying good practices and governance gaps in the policy formulation process based on supporting evidence that was documented and validated through interviews with KIs, and these were translated into strengths and weaknesses through the SWOT analysis. The PBQ allowed the KIs to elaborate on the policy formulation process they were involved in and the external factors that affected it. Thus, these questions elicited in-depth information that was translated into opportunities and threats based on the claims and the perceptions of KIs. Based on the findings and the SWOT analysis, the recommendations below were generated.

Box 3: Recommendations to Policymakers for the Future Policy Formulation Process Based on the Results Generated by the Pilot of the Tool

- National committees/working groups responsible for policy formulation should be officially/formally formulated by a ministerial decree or by a similar mechanism.
- Mandate for work including TORs, roles and responsibilities, and timeframe need to be set and documented.
- The inclusion of public (patients and beneficiaries) as well as parliamentary members, if possible, is recommended
- Involve media in the policy formulation process to sensitise them from early on regarding issues related to the concern policy; training the media on tackling health issues is recommended.
- It is extremely important to document minutes of meetings and share them with all stakeholders.
- Allow people to join the meetings via skype or webinar
- Need to form a participatory body to oversee the implementation of the strategy (it could be the same as the national committee formed to develop the strategy); ensuring participation throughout the policymaking cycle is crucial for good governance.
- Operational plans/implementation plans should be published and shared with all.
- The public need to be informed regarding draft policies/strategies and should be given the chance to forward feedback and comments. This is consistent with a decree that was issued by the Lebanese council of ministers in 2012, asking all ministries to post draft policies and strategies on their websites for at least two weeks for the public (including scientific entities, academia, media, and the lay people) to comment on.
- All participants should sign MoUs and conflict of interest declaration before being engaged in the policy formulation.
- MoH/national programme should set formal accountability mechanisms to hold various stakeholders accountable during formulation as well the implementation phase.

- MoH/national programme should work on setting standards, sanctions, as well as incentives.
- MoH/national programme should set in place a complaints system and publish results of complaints investigations.
- MoH/national programme should disseminate progress reports as well as M&E reports and other relevant documents to all stakeholders and publish these on their websites.
- MoH/national programme should develop and publish financial reports on the sources of funding, how funds were allocated, and spent. Financial information should be taken into account when formulating a policy.
- Needs assessment targeting the public should be conducted before the formulation of health policies as well as after implementation to assess responsiveness of the policy to public needs as well as to the services provided as a part of the policy.
- There is a need to have a specialised unit/staff for research analysis for policy making
- A benefit package should be clearly stated within a policy/strategy with a timeframe to provide services as well as setting a referral system so the patients/service users know what to expect.

The results and the recommendations of the pilot were presented to the policymakers and were shared with the national team for their reflection, feedback, and to set their priorities to work on based on these recommendations. The mental health team implemented some of the recommendations while they were developing a new national strategy related to substance abuse.

The pilot was able to demonstrate the positive qualities and advantages of using the tool based on specific aspects in terms of covering multi-dimensions of governance in a detailed and focused/specific manner, findings to be supported by evidence, and enabling the development of practical recommendations based on the gaps identified that can be acted on in future. In addition, the tool can have wider implications for learning in relation to the development of other policies in the future. Finally, to prove that the tool is reliable, it should be conducted in other countries/settings.

5.1.4 Feedback from the KIs and Others on the Tool

The KIs were also asked during the interviews of their opinion about the tool regarding the questions and its structure. Their comments were mainly about the structure and the usefulness of tool and to a lesser extent the content. The table below summarises the positive comments as well as criticism, and as can be seen, some were attended to, while other matters could not be addressed.

Table 17: Summary of the Feedback Received on the Tool by KIs

Positive Feedback	Critiques
• It serves as a guide • It has highlighted certain things that can be done differently the next time • It is an educational tool/checklist and is useful • It is a new topic to be tackled • The process it is suggesting is interesting • It gave a chance for reflective thinking on how the process went and identified gaps • It engages the responder on his/her citizenship and acts as a reminder for commitments • Inclusion of public in health policies is an important aspect that was missed and this tool will push policymakers to tackle this • It helps to think outside the box to include all stakeholders including other sectors and other ministries • It is educating stakeholders about governance • It is a comprehensive/exhaustive list, detailed, well designed, specific questions, explicit, well written • The tool is enjoyable and interesting • It was a good idea to have two interviews with a time interval to allow reflection	**Critiques that were taken care of** • Some wording need to be improved • Questions need to be clearer and simpler • Some terms require definitions and others need to be explained • Section one of the questionnaire could be shorter as there is some redundancy **Critiques not tackled** • Highlighted things are not applicable but important • Section one is long and was recommend to comprise two versions: a long one for direct stakeholders (policymakers) and a shorter one for others • It is long (was partially addressed)

As for the feedback that was received concerning the length of the tool, I am quoting here different KIs:

- "It needs time to think about the answers, but it is challenging and enjoyable."
- "Although long yet it is an important tool and worth the time."
- "I enjoyed it and did not notice the time and it is worth it."

One of the main concerns about the tool was its length, as discussed previously in Chapter Four; the Delphi experts emphasised the importance of getting the number of questions down to a much tighter and coherent structure of questions by concentrating on the most salient aspects of the principles of GG.

- *Feedback by Others*

The result of the pilot on the mental health strategy development process was shared with the relevant national team and policymakers. One high official said after seeing the results and the recommendations: "the tool depicts reality of how things were done. Recommendations are very useful and we have already started using them for other strategies. This exercise has been very useful for us".

Other feedback was received from one of the policymakers from another country who participated in the consultation meeting when the final version of the manual and the tool were shared with him: "The tool looks more sensible and applicable. In fact, since being in the loop with this research, I have developed an interest in making this practical and have advocated using the tool in our context. We are happy to tailor and pilot the tool on the national action plan for the prevention and control of NCDs that we are developing in our country".

In addition, the results of the pilot were presented as a poster at the Houston Global Health Collaborative GLOCAL conference that took place on 9–10 March 2018 in USA, under the title "Evaluation of a National Health Policymaking Formulation Process from a Governance Perspective". It was submitted under the category of evaluation of program, innovation and sustainability. The participants praised the data presentation as traffic lights as a smart way to attract the attention of policymakers on the findings. One participants from a developing country who works at the ministry of health showed interest to get the tool to conduct in her country, and she sent an official request after the conference (see Figure 4 for the poster presented).

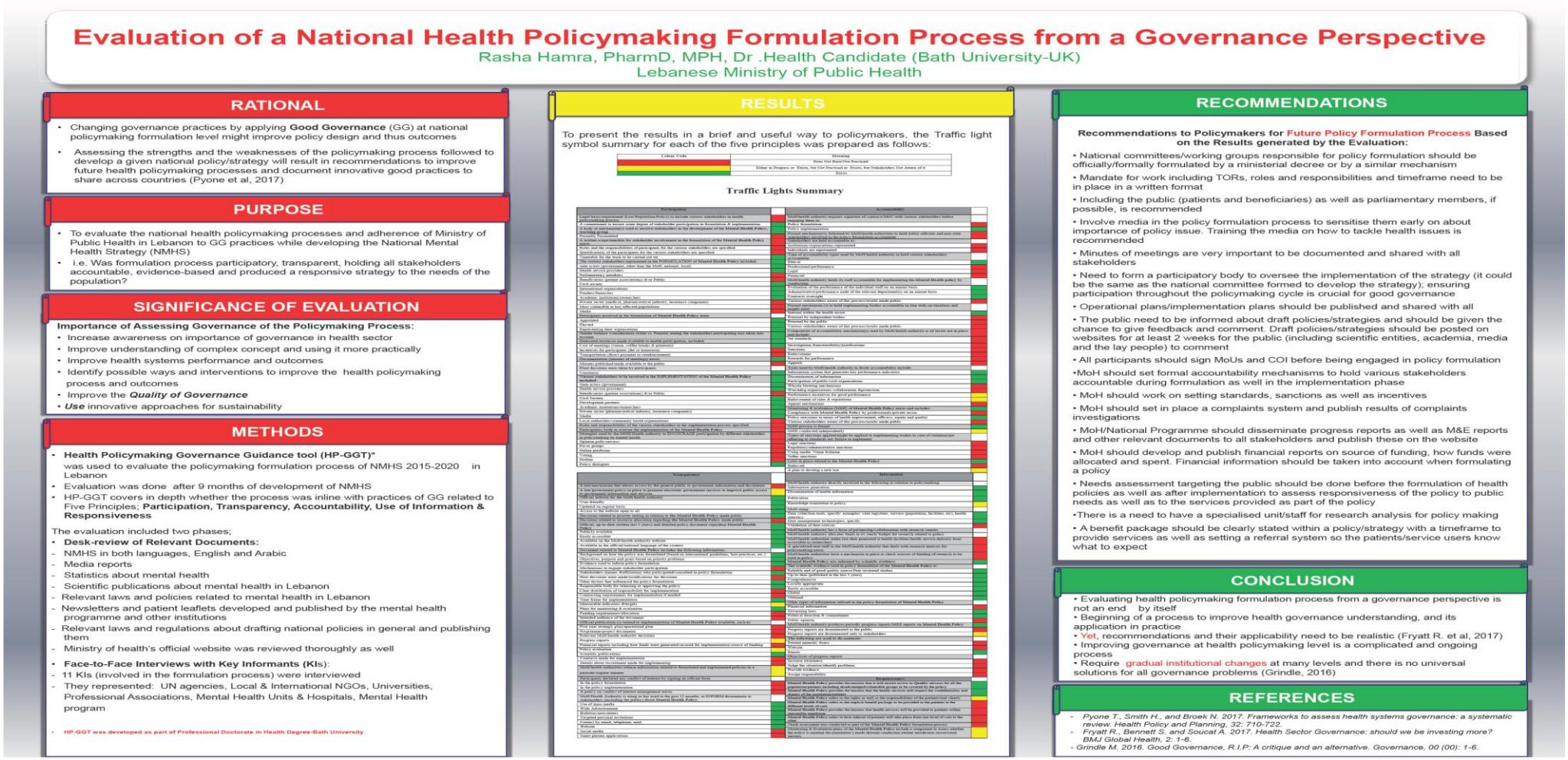

Figure 4: Poster Presentation of the Pilot Result at GLOCAL 2018

5.1.5 Outcome of the Pilot

Based on the results of the pilot testing phase and the feedback received, the tool was adjusted accordingly. The changes made to the tool after the pilot included adjustment of some wordings of the questions, such that some terminologies were replaced for better understanding. The changes also included removing duplicate questions within the same principle and between principles as there was some kind of overlap (this is due to the interrelationship between the principles, as discussed in chapter three) and repetition, mainly reflected between questions and sub-questions and between EBQ and PBQ. As a result, the sub-questions of the EBQ were reduced and a few questions in the PBQ section were removed.

The accountability section was revised and adjusted to reflect coherence and applicability. The revision of this section included clarifications of questions, adjusting sequence of questions, and removal of duplications. One question was split into two as it created confusion when asked as a main question and a sub-question.

The responsiveness section received positive feedback from the KIs as it is highlighting important aspects that are usually overseen by policymakers but were important to ask the KIs about and explaining what responsiveness to the needs means in practical terms.

The number of questions before the pilot were 52 and 36 for EBQ and PBQ, respectively and afterwards these became 53 and 30, which made the tool more practical.

It was clear from the pilot that the unit of analysis could be MoH/health authorities or even the national programme and thus this option was added. This reflects that the tool might need some adjustments depending on the policy type and the context/country being used in. This can be done without affecting the content and the validity of the tool.

5.2 The End Product of the Research

Table 18 presents sample questions from the section on participation before and after all of the refinement process, illustrating what questions were kept, added (justifications in chapter four) or deleted (justifications at the end of Table 18). All the changes that were introduced to the tool were explained and justified in chapters three, four and five.

Table 18: Sample Questions Edited, Added, and Deleted from the Evidence-Based Section on Participation to Compare the First Draft of the Tool with the Final Tool after the Delphi

First Draft: Participation	Final Tool: HP-GGT: Participation
Is there a legal obligation (law) to include various stakeholders in the health policymaking process? • In policy formulation: Y/N • In policy implementation: Y/N • Not specified	Is there a legal basis/requirement (law/regulation/policy) to include various stakeholders in the health policymaking process? *(Assessor: Read the response options and circle the answer given by the key informant)* Y, N, P, DK, NA If Yes, please specify what is it? and in what phase of the policymaking process is it specified to consult with stakeholders If No, is there still a commitment from the MoH/health authority/National Programme to ensure some degree of stakeholder participation in the formulation and implementation of national health policies?
Is there a mechanism(s) used to involve participants in the policymaking process that is concerned with…? such as: • National committee • Advisory board • Working groups • Other, please specify	Was there a body or mechanism(s) that was used to involve stakeholders in the policymaking process that was concerned with the development of the X Policy? Y, N, P, DK, NA If Yes, what body or mechanism (s) was used to involve stakeholders in the policymaking process that was concerned with the X Policy? *(Assessor: Read each response option, allow key informant to reply, and check by adding (√) all options that key informants identify)* A national committee An advisory Board Working group (s) Other, please specify:
Is the mechanism(s) for participation (indicated above) provided for by: • Law • Ministerial decree • Administrative decision • Other, please specify Is the participation process in policy formulation: • Formal • Informal	How was this body /mechanism (mentioned above) formulated? Formally (in written format), please specify how and by whom Informally, please specify how If it was formally formulated - Was there a written scope/mandate for stakeholders' involvement in the formulation of the **X Policy**? Y, N, P, DK, NA

- Is there written scope/mandate for the various stakeholders involved in policy formulation? -Y/N If it exists, what is the mandate?	What is the scope/mandate for the stakeholders? Were the roles and the responsibilities of the participants for the various stakeholders specified? Y, N, P, DK, NA Were the qualifications of the participants for the various stakeholders specified? Y, N, P, DK, NA Was there a timetable for the work to be carried out? Y, N, P, DK, NA
- Are the following stakeholders represented in the policy formulation that is concerned with….? - State actors (government), please specify. - Health service providers (professionals & Organisations), please specify. - Beneficiaries &/or public, please specify. - Civil society, please specify. - Media - Others, please specify	- Were the following stakeholders represented in the FORMULATION that was concerned with **X Policy?** State actors (Government, other than the MoH, national, local), please specify. Health service providers (professional association/unions/orders &health service organisations/hospital boards), please specify: Parliamentary members Beneficiaries (patients associations) &/or public, please specify. Civil society, please specify. Development partners/international organisations, please specify. Funders/donors, please specify Academic institutions/researchers, please specify. Private sector (medical, pharmaceutical industry, insurance companies), please specify. Most vulnerable or key affected populations, please specify. Media Others, please specify. Were representatives from local/regions within X Country represented? How?
	For each category of stakeholders identified above, how were the participants involved in the formulation of X Policy selected? Appointed, nominated , were there set criteria for the selection?

	Elected, by whom? Self-selected Others: Was their participation: Voluntary Mandatory
Is it specified in the mandate the level of participation? Consultation/Partnership Delegated power and control -Not specified	**Deleted** Justifications for the deletion: As it is difficult to specify such data in the mandate but the answer can be reflected from practice
Is there a balance in the mix of stakeholders' participation in policy formulation? Public vs. private Y/N	**Deleted** Justifications for the deletion: The answer can be extrapolated once we know who were the stakeholders involved
	Added Is there a gender balance /consideration (male vs. female) among the stakeholders participating in the formulation of the X Policy? Y, N, P, DK, NA
	Added Is there a participatory body to oversee the implementation of the X Policy? Y, N, P, DK, NA

From the table above, it can be seen that the final tool in comparison to the first draft has improved tremendously in terms of wordings, answer options, sub-questions have been expanded, and instructions for assessors have been added. All of these changes reflect the advantages of all the stages performed within this research towards the aim of producing a robust, useful, and practical tool to assess health policy governance (see also annex 4 for the first draft of tool before Delphi and annex 7 for the final tool to see how it improved in terms length, content and structure).

Based on the pilot and how things function in real life, it offered a considerable of insight that was included in the manual, developed after the pilot for use by future assessors. It includes justifications for all questions in the tool whether based on literature or additions suggested by the Delphi experts (see attached final tool and manual in annexes 7 and 8). The box below presents the outline of the manual.

Box 4: Outline of the Manual

Chapter I: Introduction to Health Policymaking-Governance Guidance Tool (HP-GGT)
- Background
- Rationale for Development of HP-GGT
  Process of Development of HP-GGT

Chapter II: Overview of HP-GGT
- Overall Objectives of HP-GGT
- Scope of HP-GGT
- Structure of HP-GGT

-Chapter III: Methodology of Conducting HP-GGT
- Users of HP-GGT
- Steps to Conduct HP-GGT
- Data collection: Desk Review and KI Interviews
- List of Suggested Documents to Be Reviewed
- List of Potential KIs to Be Interviewed and Sampling Strategy
- General Tips for Interviews
- Displaying Results, Analysis of Findings, and Recommendations
- Final Assessment Report

Chapter IV: HP-GGT: Questions and Explanations for Questions
- Section A of HP-GGT: Evidence-Based Questions: For 5 principles with Explanations for Each Question
- Section B of HP-GGT: Perception-Based Questions: For 5 Principles with Explanations for Each Question

Chapter V: Limitations
Glossary
Annexes
Annex 1:
- **A.** Letter Addressed to KIs
- **B.** Information Sheet
- **C.** Informed Consent

Annex 2: Sample Excel Sheet for Data Entry

5.3 Reliability Testing

For the purpose of this pilot, the reliability testing was planned using test-retest reliability or inter-rater reliability, in which the tool was supposed to be conducted by two different people (myself and an independent person with a masters degree in public health who was recruited for this purpose) and the results compared (Devellis, 2003) and correlated accordingly (Chung, Pillsbury, Walters, Hayward and Arbor, 1998) to determine the extent to which the two independent raters agreed on their interpretation of results (test agreement) (Devellis, 2003). The independent assessor was supposed to re-conduct two to three interviews with the same KIs and those were to be randomly selected to test the reliability of the tool.

Unfortunately, all the four KIs who were approached for the interview for re-conducting by another assessor refused to do so due to the time it took the first time (although they were informed in the initial information sheet sent that they might be selected a second time, with a less than 20% chance of being re-interviewed) and insisted on the fact that their answers will not change. So, the reliability was dropped due to the difficulty involved in conducting it as planned in a real life setting.

The consistency of the data generated by the tool should be studied in the future after applying the tool in different settings/countries with different types of policies.

5.4 Reflection on the Pilot

In general, the pilot went well and as planned, except it took more time than was planned. The specific contribution of the pilot, as discussed above, was mainly to test the KIs interest and willingness to participate in such research, acceptability of the questions, wordings used, and the length of the tool, removal of duplicate questions, feasibility of collecting and reviewing the relevant documents, amount and the usefulness of the information that can be generated by the tool, how this information can be analysed, and how the results can be presented in a logical manner. In addition, the pilot was helpful for developing instructions and tips to be added to the manual for future users based on observations from the field, and to finalise the tool. The acceptability, feasibility of conducting the tool ,and the usefulness of the results generated was demonstrated in the

context of a LMIC. This is valuable as the tool is intended to be used in such countries (as discussed in Chapter Two) for better understanding of health governance issues and its improvements.

The overall contribution of the pilot was mainly to demonstrate if the research reached its main aim, developing a SMART tool (as discussed in Chapter Two), which is practical yet robust and can contribute to policymakers' reflexivity to improve their policy governance practices (that are related to identified key good practices, important for high-quality governance), and this was effectively demonstrated.

With the end of the pilot testing, which was followed by finalising the tool and the manual, this research was concluded. This does not imply that this is the final step for the tool. It is a dynamic/live tool as it will continue to be adjusted, and it will undergo further revisions if needed after being used "in the field" in other countries (hopefully) with different types of health policies in different contexts. One of the advantages of this tool is that it is a generic tool that can be used to assess the formulation process of any type of policies (as discussed in Chapter Two).Furthermore, the tool is not an end by itself, but rather the beginning of a process to improve health governance understanding, importance, and application in practice. Yet, the recommendations and their applicability need to be realistic (Fryatt et al., 2017). In addition, this tool, if applied in various countries, will help in generating and documenting what different countries are doing to improve their HSG at the policymaking level, which is recommended for "collective action across countries" to improve governance (Fryatt et al., 2017). However, further research is required to explore the "good practices" that are suitable for different settings. In conclusion, the last phase of the research included pilot testing of the tool. The pilot was important to test the practical aspects of the tool and demonstrate its advantages and show how the KIs and the national policymakers perceived the tool and its findings. Certainly, the pilot's contribution to the tool's development was limited to adding the final touches on the tool after testing its practicality, while the Delphi and the consultation meeting were essential for the development of the content, structure, and methodology to conduct the tool.

Chapter Six

Conclusion

In this final chapter, I offer a brief overview regarding the importance of HSG , the gaps in Knowledge, and the lack of a practical tool to justify the focus of this research. I present a brief summary of the contribution of each of the three phases (the academic literature review, Delphi consultations, and policymakers' input and the pilot). Subsequently, the significance of this research as a whole with regard to its contribution to existing knowledge and possible contribution of health governance to policy practice is covered as well.

I present the key limitations of the tool stemming from practical and conceptual origins. I conclude the chapter with suggestions for future research that should be conducted to complement this work and other existing work with the aim to gain a better understanding of HSG and determine the best ways to improve its quality in practice at the policymaking level.

- *Importance of Assessing HSG and Gaps*

A World Health Report in 2000 emphasised the importance of governance in the health sector. Soon after, governance became one of the core building blocks of any health system (WHO, 2007) due to an emerging consensus among international health agencies that identified its salience in promoting improved health outcomes, especially in LMICs (Siddiqi et al., 2009), which is yet to be confirmed by empirical evidence to explain and verify the actual relationship between HSG and the performance of the health system and health outcomes.

It was claimed that GG might ultimately lead to improved health outcomes (Barbaza and Tello, 2014), contribute to discouraging corruption in the health system (WHO, 2007), increase efficiency of the health sector (Brinkerhoff and Bossert, 2008), might raise the performance, as well as might improve the population's health status (Lewis and Pettersson, 2009), and further enable Universal Health Coverage (Hamra and Bigdeli, 2016). All of the above have contributed to the interest in expanding the knowledge on health governance and determine the best ways to practice it in the past two decades. Thus, policymakers are interested in improving governance at all levels of the health system as a part of their role to steer the sector (Siddiqi and Jabbour, 2012). Donors as well as international organisations' are also interested in enhancing health governance practices as

a pre-requisite/condition for funds for the health sector (Lopez et a.l, 2011). This importance and interest resulted in the need to make health governance "actionable" for policymakers (Barbaza and Tello, 2014). This entailed assessing HSG in a normative way to diagnose the way in which it is practiced and can be improved, essential for the concrete implementation of governance practices.

Despite the agreement concerning the importance of governance within the health system, there is disagreement with regard to its role and best ways to define the implication of governance and to operationalise its meaning in practice (Barbaza and Tello, 2014). In addition, there are a number of widely common principles for GG suggested by different organisations but in different combinations, based on different organisational priorities (WHO, 2000, USAID, 2008, Siddiqqi et al., 2009, Lopez et al.,2011). These resulted in challenges in its assessment in a substantial and beneficial manner. Consequently, international organisations and researchers are interested in developing useful assessment tools to aid policymakers in enhancing governance, filling gaps in knowledge, and initiating change in practice (Alliance HPSR, 2008). Most of the work conducted so far has been undertaken by international organisations (Barbaza and Tello, 2014), and to a lesser extent, academic institutions (Lopez et al., 2011; Baez-Camargo and Jacobs, 2011). The assessment tools that were developed had limited application in practice due to several factors (as discussed in Chapter One). Hence, there is a necessity to produce a policy tool based on academic research, which is also practical and useful, in order to enable a better understanding of GG in practice.

This present work involved following an evidence-based approach to address some of the gaps in knowledge and practice and to assist policymakers by benchmarking good practices in diverse contexts, as discussed in Chapter Two. The tool developed for this research was designed to address this challenge by developing concrete applications of selected principles to improve upon the abstract approach previously followed by others.

HP-GGT is built on current and previous work conducted by others as it constitutes a good strategy to advance governance research; we need to focus on areas on which there is consensus and which others did not explore (Robichau, 2011).

- *Defined Scope of HP-GGT*

Drawing from the ten principles derived from Siddiqi et al.'s (2009) work, with its aim directly related to HSG, five were selected for inclusion in the proposed tool, namely, participation, transparency, accountability, use of information, and responsiveness. The

reason behind the selection of these five principles is their importance to health governance, as discussed in Chapter Two.

The level of analysis is policymaking formulation level. This renders HP-GGT one of the few tools that focusses exclusively on the governance of health policy development level as most tools reported in literature focus on either both formulation and implementation or on implementation alone (Gilson and Raphaely, 2008; Siddiqi et al., 2009). Changing governance processes through the application of GG at the formulation level might improve policy design (MacGregor, Singleton and Trautmann, 2014). The unit of analysis is MoH/Health authority since it is the steering entity responsible for setting national policies, regulations, and plans. It is important that MoH/health authorities assume a leading role in conducting the assessment to allow a sense of ownership and utilise results to better inform policy formulation processes and improved governance of the system. Defining the scope of the tool was performed as a part of the initial proposal and was not subjected to the Delphi consultations.

Few tools on HSG offer a combination of data collection approaches. The HP-GGT combines both evidence-based and perception-based questions. EBQ provides a snapshot of the situation at a given time and can be utilised to track changes, while PBQ add in-depth understanding of the processes, explains the changes, and reflects on the content.

- *Contribution of Each of the Research Phases to the Tool's Development*

The research was executed as a step-wise process through three phases.

Phase I conceptual and framework development: This involved building a strong conceptual foundation for the tool based on the available literature from which the first draft was created. This was achieved through the conceptualisation of the five principles in terms of identifying their key characteristics/aspects/concepts. Armed with the knowledge from other works regarding these principles, the basic form of the tool was formulated.

Phase II content and methodology refinement of the tool: This focused on refining the tool's content by seeking informed expert opinion through a modified Delphi process. Governance experts contributed to agreeing on the core concepts that should be attributed to the five principles selected for assessment through the tool's application. They also contributed to making the concepts more relevant to health governance policy. In addition, they also proposed new concepts to complement the assessment of the principles, thus ensuring the tool's construct validity.

The Delphi process was followed by consultation with high-level policymakers, who were mainly engaged to assess the tool's practicability in the context of health, while they also offered further suggestions for its modification, as presented in Chapter Four.

Phase III applicability and testing of the tool: The pilot testing of the tool took place in a middle-income country, Lebanon. The formulation process of the newly developed National Mental Health Strategy was assessed to demonstrate the tool's practicality with regard to data collection, usefulness of the data generated to offer recommendations for future policy improvements, as demonstrated in Chapter Five.

- *Contributions of the Research*

The contribution of this research can be considered at two levels. At the level of knowledge, it has contributed to an enhanced understanding of governance and its principles in relation to health policymaking. The application of the Delphi method contributed to bridging the gap in academic research concerning health governance for its practical application at the policymaking level. This implies that collaboration in the identification of the main concepts in the literature with groups of experts, some of whom came from an academic background while others had practical experience in the field of HSG, constituted a novel input of this research endeavour. Thus, at the level of policy application, the proposed HP-GGT that contains a list of good practices can be implemented to enhance and improve the governance of the policymaking process. A practical advantage of the tool is that it covers multi-dimensional aspects that once assessed will be available for policymakers to reflect on its concrete recommendations for enhancing the quality of the policymaking governance process in their jurisdiction.

At the level of knowledge, this research resulted in bringing abstract concepts into policy application through conceptualisation and operationalisation. Most organisations define health governance by its principles. The same approach was followed. However, an in-depth exploration of the characteristics of the five of principles based on the summarised evidence obtained from the literature (not reported under health governance before) fulfilled the demand for the concrete application of the governance principles (as observed in the existing literature). These summaries constituted non-exhaustive lists of these characteristics that received consensus through the consultative and iterative discussions with knowledgeable experts. These experts identified these characteristics as the most important ones to assess and further facilitated the development of new insights by underpinning concepts not covered in the conceptualisation phase. These characteristics are employed in the tool to sensitise policymakers regarding their contribution to GG and

offer examples of good practices documented in the literature and validated by the Delphi experts.

HP-GGT is the first health governance tool developed through Delphi consultations, and it's added value is due to a lack of consensus regarding the best way to assess it due to a lack of standardised tools. Thus, the knowledge contribution was made through elaboration, specification, and the analysis of the concepts/components in relation to their principles (see Annex 9, a sample of how participation was proposed to be assessed by Siddiqi et al. (2009) vs. how HP-GGT is assessing it).

At the level of policy practice, the assessment focuses on the policymaking process and principles of governance that fall under it. It is designed to be applied to any policy type; the findings would subsequently inform enhancements to the policymaking process in general. The tool raises important questions for policymakers to reflect on and then consider them in developing health policies. The tool proposes interventions that can be utilised to enhance the gaps in governance identified. Thereafter, it is up to the policymakers to decide what is important to deal with and when, based on the recommendations generated by the tool and the context they operate in.

The end-product of this research is the tool and its manual. It can be employed as an assessment tool to evaluate a policymaking process followed retrospectively; thus, it provides an opportunity to analyse governance processes in health policy formulation. It can assess the strengths and weaknesses of the process of the policy formulation and offer recommendations accordingly. The tool and the manual can be employed like a guide/model to apply GG when developing national policies/strategies. Consequently, the tool is considered a guidance tool that can add value to the health policymaking processes and research on health policy. As the principles of governance were translated into mechanisms and specific activities, the applications of these GG principles will facilitate strengthening the institutional capacity of MoH/health authorities and their stewardship role as well as improving the policymaking process.

This tool represents the first step towards benchmarking good practises in health governance at the policymaking level. It serves as an entry point for change through mere consultation with KIs (stakeholders who were involved in the policymaking and are knowledgeable about the health sector) on the right questions. This was reflected in the feedback provided by KIs during the pilot. HP-GGT helps in providing insights and extending the consideration of potential solutions (Singleton et al., 2014). In addition, the tool emphasises the importance of documenting the policymaking process.

- *Process of Reflection*

A critical examination of the approach followed to develop the HP-GGT would reveal that it constituted as approach of reflection.

Delphi experts reflected on the content derived from the literature, contributed to it, and validated it through an extensive consensus process.

High-level policymakers considered the data collection methodology of the tool and the optimum ways to present the findings. The pilot allowed another round of reflection by the KIs, and this facilitated in the final refinement of the wording, removal of duplicates, and assessment of the tool's practicality. The final reflection took place when the findings were presented and the recommendations of conducting the tool were presented to the national policymakers, who found them useful, realistic, and comprehensive. The presentation of the findings was helpful to policymakers for visualising the strengths (green), weaknesses (red), and the processes that their application required acceleration (yellow).

The four elements together (literature search, Delphi consultation, policymakers' input, and the pilot) contributed to in-depth knowledge concerning the key pillars of the five GG principles and towards generating a simple yet practical tool that might positively influence the governance of health policy. The research resulted in a valid, rigorous, evidence-based tool that can produce useful information. Thus, it can be utilised by national policymakers and international organisations interested in working on HSG at the national level.

- *Limitations*

The HP-GGT does not represent a perfect tool; like any other instrument of its kind, it has some limitations that can be classified into practical and conceptual ones.

Practical limitations include the need to conduct a series of interviews and extensive review of available secondary information. The findings of the assessment will depend greatly on the existence of relevant documents to be reviewed, given that the culture of documentation in some LMICs countries might be poor. Furthermore, identifying relevant KIs for interviews is critical and a key element in the success of the assessment; this is because the results obtained will depend on the number of KIs who will agree to be interviewed, their level of knowledge concerning the policy process under evaluation, and their openness in responding to the questions. It is crucial to engage a relevant mix of KIs in order to gain a multi-perspective reflection regarding the policy development process from a governance perspective. A proper mapping of the stakeholders is an absolute necessity before initiating the assessment as it was done in the pilot (Chapter Five).

Another practical limitation of the tool is that the tool is rather long, requiring a minimum of two hours to complete both sections (around one hour for each). This might result in a low rate of acceptance by KIs given their tight schedules; this is the reason due to which it was suggested that two separate interviews be conducted, if found acceptable by the KIs. Moreover, translating the tool into other languages for application in other contexts might be a problem due to the possible cultural differences, which can lead to some inaccuracies.

The conceptual limitations include a narrow scope in terms of the level of analysis and the principles covered. The level of analysis only concerns the formulation and not the implementation phase or any other phase of the policymaking cycle. A wider scope in this regard would have been preferable, in particular, because quite commonly, these phases overlap, and hence, the tools' findings would have been more comprehensive. As evident, the tool involved only five principles of GG out of the ten identified in the literature, which limited its comprehensiveness again. However, considering the fact that it has been criticised by some for being too lengthy, this limitation could be insurmountable at this stage. That is, for the tool to be practical and realistic it would seem that, if anything, it should be shorter if possible rather than longer.

The conceptualisation of the responsiveness principle was probably the weakest as it was indicated by two Delphi experts; yet, no consensus was reached on eliminating it from the tool. This weakness could be due to the fact that it was tackled in the literature only as clinical responsiveness at the service delivery level (Chapter Three). It was also the least chosen principle for review during the Delphi process; it was reviewed by eleven experts, while the most reviewed principle was participation, reviewed by fourteen (as discussed in Chapter Four). Moreover, responsiveness is classified in literature as an outcome of governance, while the other selected principles were processes (Baez-Camargo and Jacobs, 2011; Barbaza and Tello, 2014). Considering this conceptual weakness of responsiveness, it was logical to retain it in the tool to conceptually develop it further with the help of governance experts. Additionally, introducing the principle to policymakers to highlight its significance and offer a better understanding of responsiveness and its potential role at the policymaking level was helpful, starting from the policy formulation phase. Concepts of responsiveness reflected in the questions were praised by the KIs during the pilot.

Another conceptual limitation of the tool is that it does not explore the relationship between the principles as it does not suggest the most important ones, ones that are the result of others, precursor to others, and these issues remain unresolved. The reliability testing was not conducted due to practical concerns as discussed in Chapter Five.

A general limitation associated with improving governance is that it is a complicated and ongoing continuous process that would require institutional changes at several levels, and there is no universal solution for all governance problems (Grindle, 2016); furthermore, the required change cannot happen simultaneously (Grindle, 2004). Improvement in the quality of governance involves modifications in long-standing practices, strategies, interests, cultural habits, and social norms (Grindle, 2004; 2008). Thus, the process of change should be gradual. Improving all the practices that are listed within the tool at the same time is not possible due to the efforts required to do so and the negative aspects that might emerge when GG principles are applied, mainly due to the need to invest in human and financial resources and the lengthy process associated with such modifications and changes (as discussed in Chapter Three). Aiming for "good enough" governance will be a more realistic goal that would require further realistic investment for the improvements required in HSG (Grindle, 2004; Fryatt et al., 2017).

- *Future Research*

Future research should be focused on the other principles of GG within the health context (ethics, equity, efficiency, effectiveness, rule of law, and strategic vision). Moreover, the other phases of the policymaking cycle require to be investigated, possibly using the proposed tool with some modifications. Further, the subsequent research that expands on this one would further require assigning different weights to different characteristics as it will be useful to advise policymakers on installing fundamental/core components as against desirable processes/mechanisms, which will further improve the quality of governance at the policymaking level.

HP-GGT should be tested in other countries with different kinds of policy to ascertain whether it is flexible for application in other contexts and with other health policies/strategies.

There is a necessity for in-depth research to explore the relationships among the governance principles identified and their interaction in the policymaking cycle as suggested by the framework developed and discussed in Chapter Three. Identifying the nature of the relationships between the various principles can assist policymakers and others to perform better and more realistic planning of interventions to improve health governance as this would help them focus efforts on the principle(s) that will positively affect the others if enhanced.

Finally, further in-depth research is required to explain the association and to verify or falsify the causation claim between applying GG within the health system and improving its performance and eventually improving health outcomes and indicators.

In conclusion, the assessment of health governance at the policymaking level does not comprise an end in itself; rather, it forms the beginning of a complex and continuous improvement process that would require gradual institutional changes at several levels (Grindle, 2016). Siddiqi et al. (2009, p.24), stated that the "Road to GG in health is long and uneven", and I would like to believe that the tool created through this work presents a positive step along this road, one that provides the opportunity to act as a medium for initiating a concrete dialogue with policymakers who wish to enhance their governance practices at the policymaking level.

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Annexes

Annex 1. Mapping of Existing Questions on the Five Governance Principles in Various frameworks/Assessments

Framework Assessments	Principles	Questions	Data Source
Siddiqi et al., 2009	**Participation & Consensus Orientation**	- Are the private sector, civil society, line departments and other stakeholders consulted in decision making? - How are decisions related to health finalized: cabinet, parliament, head of government or state? - How are the inputs solicited from stakeholders for health policy? - How does government reconcile the different objectives of various stakeholders in health decision-making? - Are other state ministries involved in by the MOH in policies and programs to tackle health determinants? - What is the level of decentralization in decision-making? - What is the extent of community participation in health service provision?	All qualitative in nature Data collected through interviews with KIs
Kirigia et al., 2011	**Community Participation & Effective partnership for health**	- Extent to which communities (either directly or through elected leaders) are involved in the health needs assessment, national health policy development, and planning of health development - Extent to which communities (either directly or through elected leaders) are involved in management of health services and other health enhancing services - Extent to which communities (either directly or through elected leaders) are involved in monitoring and evaluation in the achievement of health development objectives and targets spelt out in national health strategic plan. -Existence of vibrant intersectoral committees for tracing progress on socioeconomic determinants of health - Extent to which the legislative and policy environment forges partnerships with the faith-based organizations and private for profit sector in health financing, health systems input creation and health services provision to facilitate implementation of national health policy & strategic plan	Survey among parliamentarians and civic leaders or administrative leaders -In-depth interview with prime-minister/president office -Review of health-related legislations and interviews of leaders of faith-based and private for profit health service providers

Veillard et al., 2011	**Ensure Good Governance supporting achievements of health system goals**	-To what extent was the formulation process for the vision for health and health system strengthening strategy inclusive of main stakeholders for national consensus and ownership? -Are common values shared across the health sector and is an ethical base for health improvement established? - Are health-system wide accountability and transparency ensured? - Are there strategies in place to engage and involve patients and citizens in shared decision-making and priority setting? - Are the roles and responsibilities of the public, private and voluntary sectors and of civil society specified in implementing the health strategy? - Is there a strategy in place to collaborate and build coalitions across all sectors in government, and with actors outside government, to attain health system goals?	-Comparative case studies of countries across the WHO European region
USAID, 2012: HSA	**Voice: Preference Aggregation**	-The public and concerned stakeholders have the capacity and opportunity to advocate for health issues important to them and to participate effectively with public officials in the establishment of policies, plans, and budgets for health services -Willingness of the public and concerned stakeholders to participate in governance and advocate for health issues	-Interviews with wide range of KIs, and ask for examples
Siddiqi et al., 2009	**Accountability (Internal & External)**	- What is the role of press/media? - What is the role of elected bodies (legislature)? - What is the role of judicial system? - Are mechanisms for overseeing adherence to financial, administrative rules in place? - What evidence is present about the effective enforcement of accountability processes?	All qualitative in nature Data collected through interviews with KIs
Kirigia et al., 2011	**Accountability & Transparency in health development**	-Existence of transparent results-oriented reporting and assessment frameworks to assess progress against national health strategic plan target indicators - Extent to which diagnostic reviews of national arrangements and procedures for public financial management, accounting, auditing, procurement, results frameworks and monitoring	-Review reports of the public expenditure and financial accountability (PEFA) initiative, if does not exist, conduct the PEFA assessment

		provide reliable assessments of performance, transparency and accountability of country systems - Extent to which evidence from diagnostic reviews is used in the design of reforms to ensure that national systems, institutions and procedures for managing all health resources are effective, accountable and transparent - Extent to which reliable and timely budget execution and audit reports are transparently reviewed by relevant parliamentary committees and published in mass media for public scrutiny	
Veillard et al., 2011	**Make use of legal, regulatory and policy instruments to steer health system performance**	-Does the ministry of health ensure that legislation and regulations are fairly enforced? - Is the right mix of powers, incentives, guidelines best practices and sanctions used to steer stakeholders in the chosen direction? - Are the health system incentives aligned to make sure that they support the attainment of policy goals?	-Interviews with KIs
USAID, 2012: HSA	**Client Power: Technical & Oversight**	-Civil society organizations (including professional, NGOs, media, etc) oversee health providers and provider organizations in the way they deliver and finance health services (acting as watchdogs) -The public or concerned stakeholders (e.g., community members) have regular opportunities to meet with health care providers about service efficiency or quality (existence of client-provider committees or similar mechanisms) -There are procedures and institutions that clients, civil society, and other concerned stakeholders can use to fight bias and inequity in accessing health services (existence of organizations for patients rights, independent judiciary body & law enforcement)	
USAID, 2012: HSA	**Oversight**	-Health sector regulations are known and enforced in both public and private training institutions and health facilities (Do government regulatory agencies have the necessary resources (human, technical, financial) to enforce existing legislations and regulation? What attempts has the government made to support compliance with regulations? To what extent have these attempts	

		been effective? -Procedures exist for reporting, investigating, and adjudicating misallocation or misuse of resources: (What are the policies in place for dealing with mismanagement? What opportunities exist for concerned citizens or health workers to report resource allocation problems, malpractice, counterfeit drugs? Is an impartial ombudsman available for investigating them? What laws exist to deal with mismanagement of health funds?	
Siddiqi et al., 2009	**Transparency**	-Is information about financial administrative procedures readily available? - How transparent is the process of resource allocation? - Are there monitoring mechanisms in place to ensure transparency of decisions? - Who is involved in monitoring of health services? - How are the district managers appointed/transferred? - How soon is information from financial audit available after the funds are distributed?	All qualitative in nature Data collected through interviews with KIs
USAID, 2012: HSA	**Transparency**	-The national government is transparent with regard to health sector goals, planning, budgeting, expenditures, and data. It regularly communicates with stakeholders in the health sector	
Siddiqi et al., 2009	**Information: Generation, Collection, Analysis, Dissemination**	-What information is available about the health system and health in the country and how accessible is it? - What is the reliability of information available for development of policies? - What evidence is there for the use of information in decision-making process? - How is the relevant information about health generated? - How is implementation of health policies monitored?	All qualitative in nature Data collected through interviews with KIs
Kirigia et al., 2011	**Evidence-based decision-making**	-Existence of a national health research system & policy/strategic plans that are being implemented as evidenced in research outputs and their use in health policy, planning and decision-making -Existence of a functional Health knowledge management systems (HKMS) that does acquisition, creation (probably through research and practice), diffusion, application and evaluation/	Review existing Health Research Systems Analysis (HRSA) reports; and where non- existent conduct an assessment of HRS using HRSA toolkit -Review existing HKMS

		improvement of knowledge -Health management information systems: Extent to which a country has legal and policy frameworks supported by sufficient human resources, financing and infrastructure; core health indicators identified covering determinants of health, health system inputs, outputs and outcomes; key data available from six main sources and standards for their use - for census, vital events monitoring, health facilities statistics, public health surveillance, population-based surveys and resource tracking; optimal processes for collecting, sharing and storing data, data flows and feedback loops; dissemination of information and effective use of data for policy and advocacy, planning and priority setting, resource allocation, and implementation and action - Existence of a comprehensive national policy and a legal and strategic framework to guide and nurture the growth of Information, communication, & technology (ICT), while at the same time protecting the welfare of its citizens -Extent to which the necessary investment in ICT Infrastructure, including fixed phone lines installation, equipment (e.g. computers, servers, networks) and Internet connectivity in the entire health system, i.e. from the Ministry of Health headquarters down to the level of community-based public health programmes	reports; and where they do not exist undertake an assessment of HKMS using "Research Matters" Knowledge Translation Toolkit -Review existing NHIS reports; and where non-existent conduct an assessment using Health Metrics Network tool
Veillard et al., 2011	**Compile, Disseminate and Apply Appropriate Health Information and Research Evidence**	-Does the health ministry ensure that strategy-based information, research evidence and other important data is generated, analyzed and used for decision-making by policymakers, clinicians, other health system actors and the public? - Are research evidence and strategy-based performance information (including health system performance assessment) built into ministry policy development and decision-making processes?	
USAID, 2012: HSA	**Information, Reporting & Lobbying**	-Public and private sector providers report information to the government (Issues to examine are: type of data reported, timeliness of reports, quality, and ease of use by policymakers, and if	

		used in policy, planning and monitoring) -Service providers use evidence to influence/lobby government officials for policy, program changes	
	Resources	-Government officials rely on research and evaluation studies and existing HIS when they formulate laws, policies, strategic and operational plans, regulations, procedures, resource allocation decisions and standards for the health sector	
Siddiqi et al., 2009	**Responsiveness**	-Are health subsidies targeted? What is the targeting mechanism? - Is needs assessment conducted as part of the policy process? - Does the health policy address the health needs/burden of the local population? - Is the quality of health services and user satisfaction valued high by the MOH? - How does the health system respond to regional/local priority health problems? - How responsive are the health services to the medical and non-medical expectations of the population?	All qualitative in nature Data collected through interviews with KIs
Kirigia et al., 2011	**Responsiveness to communities non-medical expectations**	-Extent to which health systems exercise respect for persons (dignity, autonomy in choice of interventions and confidentiality) and are client oriented (prompt, adequate basic amenities, access to social support networks, choice of provider)	Exit client surveys among samples of different levels of health facilities, regional and district hospitals and health centers
Veillard et al., 2011	**Ensure alignment of system design with health system goals**	-Is the health system able to adapt its strategy and policies to take into account of changing priorities and health needs?	-Desk-review of documents, and interviews -Results will be reported as SWOT analysis table
USAID, 2012: HSA	**Government Responsiveness**	-What mechanisms are in place to ensure the participation of key stakeholders in the health policy agenda? Which groups are represented during these discussions? -Mechanisms and strategies used by the government to engage all health stakeholders in policy and planning include workshops to discuss policies and develop strategic plans, and widespread distribution of policies and plans to all major health entities	

WHO, 2010: Monitoring the building blocks of health systems	**Health System Governance**	-Existence of an up-to-date national health strategy linked to national needs and priorities -Existence and year of last update of a published national medicines policy - Existence of policies on medicines procurement that specify the most cost-effective medicines in the right quantities; open, competitive bidding of suppliers of quality products -Tuberculosis—existence of a national strategic plan for tuberculosis that reflects the six principal components of the Stop-TB strategy as outlined in the Global Plan to Stop TB 2006–2015 -Malaria—existence of a national malaria strategy or policy that includes drug efficacy monitoring, vector control and insecticide resistance monitoring -HIV/AIDS—completion of the UNGASS National Composite Policy Index questionnaire for HIV/AIDS -Maternal health—existence of a comprehensive reproductive health policy consistent with the ICPD action plan -Child health—existence of an updated comprehensive, multiyear plan for childhood immunization -Existence of key health sector documents that are disseminated regularly (such as budget documents, annual performance reviews and health indicators) Existence of mechanisms, such as surveys, for obtaining opportune client input on appropriate, timely and effective access to health services	-Rules-based indicators; whether a country has an appropriate policies, strategies, and codified approaches for health system governance -Data sources: Review of national health policies in respective domains (such as essential medicines and pharmaceutical, TB, malaria, HIV/AIDS, maternal health, child health/immunization).

Annex 2. Information Sheet—Delphi Experts Governance Assessment Tool for Health Policymaking

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How can national and international policymakers evidence and benchmark the quality of health policy governance in diverse developing country contexts?

Your expertise is sought to contribute directly to research which is developing a Health Policymaking Governance Assessment Tool, HP-GAT.

HP-GAT is intended to offer national and international stakeholders a robust, rigorous and practical assessment of the characteristics and quality of governance in health policy.

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According to WHO, Governance in health is an essential element for achievement of the health millennium development goals since Governance is considered one of the core components of any health systems. Assessing and understanding governance at all levels of the health system is crucial in order to understand how to improve its performance. Previously several assessment tools of health system governance have been proposed, but for a range of reasons, they are not widely used. Thus, there is a need to develop practical tools that are based on academic basis.

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Purpose of the Research

This research is focused on methodological work to develop a *SMART* governance assessment tool. That is, the aim is to develop an assessment tool which is capable of analysing health governance in developing countries in a Specific, Measurable, Achievable, Realistic and Timely manner. The HP-GAT should be a valid, reliable and practical assessment tool to examine whether key governance principles are practiced at the policymaking level. The key principles, as identified from existing research, are: participation, transparency, accountability, use of information and responsiveness.

The selected governance principles will be assessed in relation to the health policymaking process, focusing on formulation and implementation. The HP-GAT is designed to be applied to the assessment of Ministries of Health/Health Authorities, that is, to the governance of health policymaking at national level. It can be used as an entry point by policymakers and/or international organizations to assist Ministries of Health (MOHs)/Health Authorities to better govern their health systems as the tool can be used as a checklist of "Good Practices".

Outline of the Project

1. Develop initial assessment tool, using existing research to identify key governance principles based on literature review and previous work on health governance, and processes of assessment tools development.
2. Improve the organisation, principles, questions and practicality of the initial assessment tool in an iterative Delphi-method consultation with experts.
3. Pilot test the developed assessment tool among policymakers in 1 to 2 developing countries.
4. Finalise the assessment tool in light of pilot testing.

Description of the Assessment Tool

The assessment tool is a structured questionnaire, divided into five sections (Sections 1-5). Each section is concerned with one of the key governance principles: participation, transparency, accountability, use of information and responsiveness. Each principle is assessed separately in relation to how it is applied in policymaking process mainly at formulation and implementation.

For each principle, the assessment tool has two sets of question (A&B). The first set is evidence-based questions that evaluates the existence of certain structures, procedures, guidelines, legislation that indicate the application of the governance principle. Answering these questions could be done by desk-based research. Answers in this part of the assessment questionnaire might be given scores or follow a “Traffic Light System” that can be used to evaluate progress or changes over time.

The second set of questions is perception based that evaluates the perceptions of key informants/stakeholders about practices of good governance. This would be done via semi-structured interviews. The assessment tool is designed to be flexible enough to analyse processes of policymaking of any type of health policy (example: primary health care or pharmaceutical policies and others), and to be adapted to country context.

Description of the Process of Participation in this Study-Delphi Phase:

We are currently in the process of evaluating the developed tool with "Governance Experts" within and beyond the health sector (like you) to seek your informed expert opinion on the rigor, content, relevance and conceptual organization of the tool as well as its feasibility and practicality in order to maximize its content validity. We are seeking your opinion (in addition to other experts) using Delphi Method consultation (which is a

flexible group method that does not require panel of experts to meet face-to-face instead through virtual meetings).

Being a Delphi expert means that you will be consulted via **email by receiving 3 successive requests (4 if needed)** for feedback on the tool and answer few questions about the suggested tool. **You will receive one questionnaire every 6 weeks and you will be given 2-3 weeks to send your feedback at each round of consultation. The expected period of the Delphi consultation to take place between July and October 2015.** A detailed schedule will be provided to you once you approve to participate.

Quasi-anonymity will be followed as experts' names participating in the Delphi will be revealed to other experts (unless you wish otherwise) while their responses will be anonymous to each other as responses will be coded. Raw data will be available only to the PI and all related documents of the study will be stored under lock for at least 3 years.

Summary of the Delphi Consultation to be followed:

Round 1:

- To assess comprehensiveness, relevance, report on any missing aspect as well as to receive feedback on wording of questions and suggested structure of the tool.
- First draft of the tool to be sent to experts constitutes a long "laundry list" of concepts identified in literature related to selected governance principles.
- Experts are asked to provide reasoning or brief justification for adding or deleting questions from the tool.

Round 2:

- To narrow down the original list to most important aspects to be assessed.
- Revised draft of the tool based on Round 1 consultation will be sent to experts to 1) revise and validate the revisions implemented from Round 1 responses and 2) select and rank items to be kept in the tool.
- Items selected by more than 50% of the experts will be retained.

Round 3:

- To get a final feedback on the tool.
- Revised tool based on Round 2 will be sent for final feedback on 1) items retained, 2) practicality and 3) feasibility of the tool.
- Overall the aim is to generate consensus between experts on final tool to be pilot tested. Another round will be suggested in case of major disagreement on the questions and rankings.

Once the assessment is finalized, it is planned to pilot test it in one to two developing countries (EMRO Region). It is hoped that the final product will be used by WHO, MOHs/Health Authorities or other international stakeholders.

Ethical Approval

This research received ethical approval from the Research Ethics Approval Committee for Health at Bath University as this research is part of the professional doctorate degree the principle investigator is doing.

Benefits to participants will be related to gaining more knowledge about governance issues at the health policy making level. Thus, transforming theoretical knowledge into practical one. Your contribution to the development of the final tool will be acknowledged. No risks of any kind will be inflicted on the participants.

For More Information you can kindly contact:

-**Principle Investigator: Rasha Hamra**, PharmD, MPH, Dr. Health Candidate at Bath University-UK

Director of Health Education & Public Relations Department-Lebanese Ministry of Health

Member of Technical Committee on Good Governance in Medicine-WHO

E-mail: [redacted], Telephone: [redacted]

Annex 3. List of Delphi Experts & Affiliation

Expert Name	Position/Title	Rounds Involved In
Dr. Ahmad Abuzaid	Head of Prevention Department Anti-corruption commission-Jordan	1
Mrs. Alia Al-Dalli	International Director MENA, SOS Kinderdorf International-Morocco Former Director of the UNDP Regional Centre in Cairo (RCC)	1
Dr. Alissar Rady	Senior National Professional Officer WHO office – Lebanon	All
Dr. Alla Shukralla	Chairperson of Association for Health and Environmental Development Head of training and research unit at the Development Support Centre Member of the People Health Movement-Egypt	2
Dr. Anwar Batieha,	Professor of epidemiology and public health Jordan University of Science and Technology- Jordan	All
Mrs. Ma. Caroline Belisario	Consultant of the Health Policy Development Program - UP-Econ Foundation-USAID Project Procurement Expert and Executive Director of Diaspora for Good Governance-Philippines	All
Dr. Chokri Arfa	Professor of Health Economics & General Director INTES/University of Carthage-Tunis	1&2
Dr. David Peters	Chair, Department of International Health-John Hopkins University	1
Ms. Didar Ouladi	National Coordinator (Head) of Public Health Department Nur University-Bolivia Member of Global technical Team on GGM-WHO	All
Dr. Fadi Jardali	Associate Professor-Faculty of Health Sciences Director-Knowledge to Policy (K2P) Center Co-Director-Center for Systematic Reviews in Health Policy & System Research (SPARK) American University of Beirut-Lebanon	All
Dr. Guitelle Baghdadi	Initiator of global program on Good Governance for Medicine (GGM) program WHO-Geneva	1
Ms. Helen Walkowiak	Principal Technical Advisor Systems for Improved Access to Pharmaceuticals and Services (SIAPS) Program Center for Pharmaceutical Management Management Sciences for Health-USA	All
Dr. James Rice	Global Lead Governance Management Sciences for Health-USA	1& 2
Dr. Jane Robertson	Senior Lecturer University of Newcastle-Australia Advisor-WHO Geneva-GGM Program	All
Ms. Karen Johnson Lassner	Independent consultant (2013 to present); formerly CSO Governance Officer for the USAID Leadership, Management & Governance Project (LMG)	All

	Management Sciences for Health (2011-2013)- Brazil	
Prof Lamri Larbi	Professor Economics University of Algiers Expert-Consultant in Health Economics-Algeria	All
Mrs. Lourdes De la Peza	Principal Technical Advisor, Leadership Management and Governance Project (LMG) Management Sciences for Health (MSH)-Mexico	All
Prof Lubna Al Ansary	Member, Health Committee , Al-Shura (Consultative) Council Saudi Arabia	2
Dr. Mahesh Shukla	Senior Technical Advisor Leadership, Management, and Governance (LMG) Project Health Programs Group Management Sciences for Health-USA	All
Dr. Maryam Bigdeli	Department of Health Systems Governance & Finance-WHO-Geneva	2&3
Dr. Nabil Kronfol	Professor of Health Policy and Management (retired) Founder and President, Lebanese Health Care Management Association National Independent expert –Lebanon	All
Dr. Nagla El Tigani El Fadil	Director of Information and Planning Sudan Medical Specialization Board, Khartoum-Sudan	All
Dr. Paulo Ferrinho	Director, Full Professor Institute of Hygiene and Tropical Medicine University de Nova de Lisboa-Portugal	1&2
Dr. Sameen Siddiqqi	Director, Department of Health System Development WHO-EMRO office-Egypt	1&2
Dr. Walid Ammar	General Director of Lebanese Ministry of Public Health Ex-Member of Executive Committee WHO (2011-2015)-Lebanon	All

Annex 4. Tool Delphi Round 1: Health Policymaking Governance

Assessment Tool HP-GAT

ROUND ONE: Instruction Sheet for Delphi Experts

This is the first draft of the tool and it constitutes a long "laundry list" of concepts identified in literature related to selected governance principles

ROUND ONE: The purpose of this round is to:

- Assess tool comprehensiveness and relevance
- Report on any missing aspect and feedback on the suggested structure of the tool
- Report on the clarity and appropriateness of questions wording

Please REMEMBER:

- **The HP-GAT is a generic list of questions,** and the tool is designed to be flexible enough to analyse processes of policymaking of any type of health policy (example: primary health care or pharmaceutical policies and others), and to be adapted to country context.
  Thus when the tool to be used in real setting, the type of policy need to be identified.
  For this exercise the type of policy is left blank…,
  i.e. Is there a mechanism(s) used to involve participants in policymaking process that is concerned with…..?
- **Unit of Analysis** is Ministry of Health (MoH)/Health Authorities

WHAT YOU ARE ASKED TO DO:

- There are FIVE (5) sections of this very first draft of the HP-GAT. You are asked to comment on the questions, content and comprehensiveness of this draft.
- You are asked to select TWO (2) sections on which to comment. **Please indicate your reason for selecting these two** (e.g. they are the most important for health policy governance, or they are most close to your professional expertise). Feel free to comment on more than two sections if you wish to.
- You are asked to read carefully the 2 sets of questions (A. Evidence Based Questions & B. Perception Based Questions) within each of these sections
- On the columns next to each question, please give your feedback on the following:

1. Is the question (and its possible answers for evidence based questions) relevant to the policymaking process?

a. If it is Relevant you just need to add R, if it is Not Relevant add NR.

If you indicate that a question is not relevant, then you are suggesting it should be removed from the tool.

b. Please provide brief justification for your answers for the relevance of the questions.

2. Does the question need editing? If it does, kindly suggest an alternative where possible.
3. At the end of each set of questions, please suggest any important items that currently not covered by the assessment tool that need to be added, with a brief explanation of their importance.
4. Also, at the end of each set of questions, please comment on the structure of the tool, and the order of the questions.
5. In the general comment section, Please give your overall overview of the assessment tool/sections reviewed and anything you would like to add or suggest.

N.B. Feel free to use as much space as you wish for the justifications, editing and comments.

SECTION ONE: PARTICIPATION at policymaking level

A. Evidence Based Questions ***Answers for these questions will be collected through desk review of relevant documents***	**Relevant/Not Relevant**	**Justifications**	**Need Editing** **Kindly Suggest Alternative**
1.A.1 Is there a Legal obligation (Law) to include various stakeholders in health policymaking process? - In Policy Formulation Y/N - In Policy Implementation Y/N - Not Specified			
1.A.2 Is there a mechanism(s) used to involve participants in policymaking process that is concerned with…..? like - National committee - Advisory Board - Working Groups - Other, Specify:			
1.A.3 Is the mechanism(s) for participation (indicated above) provided for by: - Law - Ministerial Decree - Administrative Decision - Other, Specify:			
1.A.4 Is the participation process in policy formulation: - Formal - Informal			
1.A.5 Are the following stakeholders represented in the policy formulation that is concerned with….? - State Actors (government): Specify: - Health Service providers (Professionals & Organizations): Specify: - Beneficiaries &/or Public: Specify: - Civil Society: Specify: - Media - Others: Specify:			
1.A.6 Is there a written scope/mandate for the various stakeholders involved in policy formulation? -Y/N If it exist, what is the mandate?			
1.A.7 Is it specified in the mandate the level of participation? - Consultation -Partnership -Delegated Power & Control - Not specified			
1.A.8 If there in place any other mechanisms used by MoH to encourage participation? (can choose more than one answer) - Opinion Pools - Need/Impact assessments - Surveys - Focus groups - Public Hearings - Online platforms			

- Citizens juries - Roundtables - Voting - Inter-governmental conferences - Policy dialogues - Others, specify:			
1.A.9 Is there written criteria for duties, responsibilities & obligations of various participants at policy formulation level? Y/N			
1.A.10 Is there a balance in mix of stakeholders' participation in policy formulation? Public vs. Private Y/N			
1.A.11 How the participants were selected? (can choose more than one answer) - Appointed - Elected - Self-selected - Voluntary - Mandatory - Others:			
1.A.12 Is the MoH providing financial support for participants? - No financial support - Reimbursement - Fee or Honoraria			
1.A.13 Is there documentation of participants' contribution to policymaking? Y/N			
1.A.14 Is there documentation on how decisions were made? Y/N			
1.A.15 For each of stakeholders: specify if: - Representing themselves - On behalf of organizations/others			
1.A.16 Are the decisions between participants taken by: - Majority - Consensus - Other procedures - Not specified			
1.A.17 Is there a mechanism for consensus building between various stakeholders? Y/N			
1.A.18 Are the various stakeholders consulted on regular basis? Y/N			
1.A.19 Is MoH following any of the following methods to inform stakeholders about policy development & implementation? (can choose more than one answer) - Use of mass media - Wide Advertisement - Targeted, Personal Invitations - Contact by email, Telephone, Mail - Website - Others, specify:			
1.A.20 Who is responsible for the direct Implementation of the policy? (can choose more than one answer) - MoH - Other Governmental Agency: Specify: - Private Sector: Specify: - Civil society & NGOs			

- Others: Specify:			
1.A.21 Are the following stakeholders involved in the implementation of the policy? - State Actors (government): Specify: - Health Service providers (Professionals & Organizations): Specify: - Beneficiaries &/or Public: Specify: - Others: Specify:			
1.A.22 Are the roles and responsibilities of the various stakeholders in the implementation process specified in the formulation policy document? Veillard, 2011 Y/N			
1.A.23 If there in place any other mechanisms used by MoH to encourage participation (co-production) in implementing the national policy of….. ? (can choose more than one answer) - Regular meetings - Workshops - Orientation Sessions - Others: Specify:			
OVERALL COMMENTS on Evidence Based Questions for PARTICIPATION:			

B. Perception Based Questions ***These questions will be asked to key informants through face-to-face interviews***	**Relevant /Not Relevant**	**Justifications**	**Need Editing Kindly Suggest Alternative**
1.B.1 Are all relevant stakeholders being consulted in the policy formulation of…..? Why?			
1.B.2 Is the MoH giving enough roles for various stakeholders in the implementation phase? How?			
1.B.3 What is the role of various participants/stakeholders in the policy formulation? Is it a consultative role? Is negotiation taking place? Or is there a power control by certain participants? By whom?			
1.B.4 What are the strengths and weakness of the participation process? Can you give examples where participation made an impact-for better or worse?			
1.B.5 What are the barriers and facilitators of the participation process?			
1.B.6 Do you consider the participation process effective in terms of having informed participants, ensuring response to different stakeholders & achieving policy decisions? And why?			
1.B.7 Do you consider the participation of various stakeholders in implementing the policy effective in reaching policy goals? And why?			
1.B.8 How you evaluate the process of selection of the participants?			
1.B.9 Does the MoH have the needed resources to facilitate the participation process? In terms			

of leadership? Planning? Needed information? Institutional arrangements? Etc, Explain			
1.B.10 What is the influence of powerful stakeholders in the decision making process? Who are these?			
1.B.11 What is the influence of powerful stakeholders in the implementation process? What about conflict of interest of various stakeholders?			
1.B.12 Is there any lobbying taking place by any stakeholders? How?			
1.B.13 How you see the role of MoH in encouraging participation?			
1.B.14 Tell me more about the roles of different stakeholders in decision making? Do they have different roles in agenda setting, formulation, implementation & monitoring? & How?			
1.B.15 To what extent communities are involved in the implementation process? Kirigi et al., 2011*			
OVERALL COMMENTS on Perception Based Questions for PARTICIPATION:			

SECTION 2. TRANSPARENCY at the Policymaking Level

A. Evidence Based Questions ***Answers for these questions will be collected through desk review of relevant documents***	**Relevant /Not Relevant**	**Justifications**	**Need Editing Kindy Suggest Alternatives**
2.A.1 Is there up-to-date, detailed policy document regarding…..? Y/N			
2.A.2 Does the policy document include the following information: (can choose more than one answer) - Background on how the policy was formulated - Evidence used in policy formulation - Stakeholders who participated in policy formulation - Other factors that influenced the policy formulation: Specify: - Responsible body for releasing the policy			
2.A.3 Is there official publications related to policy implementation of ….available? Such as: - Public service report - Relevant MoH decisions - Progress reports - Financial reports - Others: Specify			
2.A.4 Does the policy implementation document(s) include the following information: (can choose more than one answer) - Action Plan for Implementation - Timeline for implementation - Progress on Implementation - Outcomes on Implementation - Others: Specify			
2.A.5 Are the following documents publicly available/easily accessible to relevant stakeholders? -Policy Document Y/N -Implementation Document Y/N			
2.A.6 Are the document (s) intended for the following audience: (can choose more than one answer) - Public - Different policy actors - Media - Others: Specify:			
2.A.7 Is there a law in place about “access to information? Y/N			
2.A.8 Is there a law in place to encourage "cyber transparency"/ E-Governance? Y/N			
2.A.9 Is there an official website for the MoH? Y/N			
2.A.10 Are the policy documents published on the MoH website? Y/N			
2.A.11 Is there any report in media in the past 12 months about the policy formulation &/or implementation? Y/N			
2.A.12 Is there in place any communication strategy for the public/professionals and others to comment on the policy document and implementation process and receive feedback? Y/N , Specify:			
2.A.13 Are there written criteria for decision-making in relation to policy formulation? Y/N			
2.A.14 Is the documentation of participants’ contribution to policymaking published? Y/N			

2.A.15 Are the documents on how decisions were made published? Y/N			
2.A.16 Are the names of the participants in the policy formulation published? Y/N			
2.A.17 Are the names of the implementing bodies published? Y/N			
2.A.18 Are the roles and responsibilities of the various stakeholders in the implementation process published? Y/N			
2.A.19 Did participants in the policy formulation/implementation declared any conflict of interest by signing an official form? Y/N			
OVERALL COMMENTS on Evidence Based Questions for TRANSPARENCY:			

B. Perception Based Questions ***These questions will be asked to key informants through face-to-face interviews***	**Relevant /Not Relevant**	**Justifications**	**Need Editing Kindly Suggest Alternative**
2.B.1 What makes the policy formulation process transparent? How transparency can be best achieved?			
2.B.2 Was the policy formulation process transparent? Between participants? to the public? Why?			
2.B.3 Is the policy implementation process transparent? Why?			
2.B.4 Is the information in the policy document(s) enough in terms of completeness and usefulness? Can you elaborate?			
2.B.5 What is the importance of being transparent at the policy formulation and implementation level?			
2.B.6 Is the MoH transparent in the policymaking process? How?			
2.B.7 How can the MoH increase its transparency in the policymaking process?			
2.B.8 What are the formal mechanisms that should be in place to monitor transparency?			
2.B.9 Is the participation of various stakeholders in the formulation process makes it more transparent? How? Or, Is the transparency in the formulation process is encouraging the participation of the various stakeholders? How?			
2.B.10 What are the formal mechanisms that should be in place to monitor transparency at the implementation?			
2.B.11 Are the roles and responsibilities of the various stakeholders in implementing the policy transparent? Can you give examples?			
OVERALL COMMENTS on Perception Based Questions for TRANSPARENCY:			

SECTION THREE. ACCOUNTABILITY at policymaking Level

A. Evidence Based Questions ***Answers for these questions will be collected through desk review of relevant documents***	**Relevant /Not Relevant**	**Justifications**	**Need Editing** **Kindly Suggest Alternative**
3.A.1 Is there a formal mechanism to hold the participants/stakeholders in the policy formulation related to….accountable? Y/N			
3.A.2 Is there a formal mechanism to hold implementing bodies responsible for implementation of ….accountable? Y/N			
3.A.3 Who is held accountable from the participants/stakeholders? Can choose more than one answer: - Governmental Staff - Professionals NGO Representatives - All - Others: Specify			
3.A.4 What is the type of the accountability mechanism used? Can choose more than one answer: - Ethical - Professional/Performance - Legal - Political - Financial - Functional/Strategic			
3.A.5 Does the Accountability Mechanism include the following components? Can choose more than one answer: - Set Standards - Investigation & Answerability - Sanctions - Enforcement - Rewards for Performance			
3.A.6 Who is the authority responsible for holding the stakeholders accountable? Can choose more than one answer: - Internal within the health sector, Specify: - External by independent bodies, Specify - External by public: Specify: - Self-responsibility			
3.A.7 Is there an evaluation/monitoring of: - Policy Formulation - Policy Implementation - None			
3.A.8 Is the evaluation/monitoring process formal? Y/N - Evaluation done by whom:			
3.A.9 Are justifications allowed during the evaluation/monitoring? Y/N			
3.A.10 Is the evaluation/monitoring results disseminated? Y/N			
3.A.11 What are the types of sanctions applied to participants/stakeholders in case of violation/not adhering to standards set? Failure to implement? Can choose more than one answer: - Legal Sanctions			

- Regulatory Sanctions - Softer Sanctions, Specify:			
3.A.12 Who is entitled to impose sanctions? - Governmental bodies, Specify: - Others: Specify:			
3.A.13 Is there documentation of sanctions enforced? Y/N			
3.A.14 Are any of the following methods used to enable accountability? Can choose more than one answer: - Information System in place - Dissemination of information - Participation of Public/Civil organizations - Whistle blowing mechanisms - Watchdog organizations - Performance incentives for good performance - Enforcement of rules & regulations - Appeal mechanisms - Others, Specify:			
OVERALL COMMENTS on Evidence Based Questions for ACCOUNTABILITY:			

B. Perception Based Questions ***These questions will be asked to key informants through face-to-face interviews***	**Relevant /Not Relevant**	**Justifications**	**Need Editing Kindly Suggest Alternative**
3.B.1 Are the various stakeholders held accountable for their roles in the policy formulation? How?			
3.B.2 Are the implementing bodies held accountable for their roles in the policy implementation? How?			
3.B.3 Are all participants held accountable in equal manner? How accountability is ensured?			
3.B.4 What you think of the accountability mechanisms (ethical, professional, legal, political, financial, functional) used? Are they sufficient?			
3.B.5 Is there transparent answerability/monitoring mechanism in place for policy formulation process? Explain			
3.B.6 Is there transparent answerability/monitoring mechanism in place for implementing bodies? Explain			
3.B.7 Are there enforcement of sanction decisions? Give examples			
3.B.8 What is the importance of holding stakeholders accountable in the policy formulation process?			
3.B.9 What is the importance of holding stakeholders accountable in the policy implementation process?			
3.B.10 What is the importance of having a transparent accountable mechanism in place?			
3.B.11 What you think of the methods (Information system, participation, whistleblowing mechanisms, watchdogs, etc) used to enable accountability? Which is most			

effective?			
3.B.12 What is the role of media in encouraging accountability? Siddiqi 2009*			
3.B.13 Does the MoH ensure that regulations, legislations and sanctions are fairly enforced? & How? Veillard, 2011**			
3.B.14 What is the role of MoH in promoting/establishing accountability at the policymaking level?			
3.B.15 Does the MoH provide incentives for implementing bodies when reach policy goals?			
3.B.16 Does the civil society have an active role as watchdogs over policy implementation? How?			
OVERALL COMMENTS on Perception Based Questions for ACCOUNTABILITY:			

*Siddiqi S., Masud T., Nishat S., Peters D., Sabri B., Bile K. & Jama M. 2009. Framework for assessing governance of the health system in developing countries: gateway to good governance. Health Policy, 90:13-25.

**Veillard J., Brown A., Baris E., Permanand G., Klazinga N. 2011. Health system stewardship of National Ministries in the WHO European Region: concepts, functions and assessment framework. Health Policy, 103: 191-199.

SECTION FOUR. USE OF INFORMATION at the policymaking Level

A. Evidence Based Questions ***Answers for these questions will be collected through desk review of relevant documents***	**Relevant /Not Relevant**	**Justifications**	**Need Editing Kindly Suggest Alternative**
4.A.1 Is the MoH directly involved in the following: Can choose more than one answer: - Information Generation - Publication, Specify types of publications: - Dissemination of health information, Specify type of information disseminated:			
4.A.2 Is the MoH using the following? Can choose more than one answer: - Data Collection tools, specify: - Data Management technologies, specify:			
4.A.3 Is there an item/commitment in the strategic vision document of MoH to use research evidence in policymaking? Y/N			
4.A.4 Was the policy related to....been developed based on evidence-base? Y/N			
4.A.5 Were other types of information used in the policy formulation? Can choose more than one answer: - Health information (health determinants, health status, others), Specify: - Financial information - Governing laws - Political direction & commitment - Public Opinions - Others, Specify:			
4.A.6 How was evidence-based research utilized in the policy formulation/implementation? - Instrumental - Conceptual - Symbolic use - Not used			
4.A.7 Did the MoH publish a summary on the research evidence used in the policy formulation? Y/N			
4.A.8 Does the evidence used in the policy formulation have the following criteria? Can choose more than one answer: - Evidence of good quality - Reliable - Up-to-date - Comprehensive - Appropriate - Easily Accessible			
4.A.9 Is the evidence used: - Global Evidence - National Evidence - Local/limited evidence			
4.A.10 Is there a specialized unit in the MoH who deals with research analysis for policy formulation? Y/N			
4.A.11 Does the MoH publish regularly progress reports on implementation plans of policy? Y/N			
4.A.12 Are the progress reports disseminated to all stakeholders? Y/N			
4.A.13 What are the objectives of progress reports? Can choose more than one answer: -Increase awareness - Judge the situation - Identify problems - Provide evidence - Locate responsibility - Others, specify:			

4.A.14 Who is the intended audience for the progress reports? Can choose more than one answer: - Governmental Officials - Professionals - NGOs - Public - Donors - Others, specify:C			
4.A.15 Does the MoH fund policy related research? Y/N			
4.A.16 Does the MoH have any form of partnership/collaboration with research centers? Y/N			
4.A.17 Does the MoH provide direct incentives for researchers in the country? Y/N			
4.A.18 Was there an input from a researcher/academia to the policy formulation? Y/N			
OVERALL COMMENTS on Evidence Based Questions for USE OF INFORMATION:			

B. Perception Based Questions ***These questions will be asked to key informants through face-to-face interviews***	**Relevant / Not Relevant**	**Justifications**	**Need Editing Kindly Suggest Alternative**
4.B.1 Was enough evidence used in the formulation of the policy? What type of evidence was used?			
4.B.2 Is the MoH leadership committed to use evidence base and other types of information in policy formulation? What is the evidence for this commitment?			
4.B.3 What type of information/evidence usually the MOH use in policy formulation process? Is this information readily available?			
4.B.4 Is the MoH encouraging proper information generation, collection, analysis and dissemination of information used in policy? How?			
4.B.5 Is MoH disseminating information related to the governance of the policymaking process? What Type of information is disseminated?			
4.B.6 What is the importance of using information/evidence-base in policymaking?			
4.B.7 What are the factors that influence the uptake of information/research into policies?			
4.B.8 Do participants from outside MoH have major influence on the use of research evidence at policy formulation level?			
4.B.9 Is MoH staff trained to use research evidence? What is the level of training?			
4.B.10 Is the process of how research evidence is used in policy formulation transparent? How?			
4.B.11 Can you describe the relationship between MoH leadership and researchers?			
4.B.12 Is research evidence use in policymaking a priority for MoH? What is the evidence for this claim?			
4.B.13 What other factors (other than evidence-base) contributed to the formulation of policies?			
OVERALL COMMENTS on Perception Based Questions for USE OF INFORMATION:			

SECTION FIVE. RESPONSIVENESS TO THE NEEDS OF THE POPULATION at the policymaking level

A. Evidence Based Questions ***Answers for these questions will be collected through desk review of relevant documents***	**Relevant / Not Relevant**	**Justifications**	**Need Editing Kindly Suggest Alternative**
5.A.1 Is there a public policy against discrimination in the health system? Y/N			
5.A.2 Does the policy document relate to ....mention that it will not impose any discrimination? Y/N			
5.A.3 Does the action plan relate to implementation of ....mention that it will ensure respect to all? Y/N			
5.A.4 Is there a law in place to allow participation of lay people/public in policy formulation? Y/N			
5.A.5 Do the participants in the policy formulation include representatives of the public? Y/N Specify representing whom:			
5.A.6 How these representatives were selected? - Appointed by MoH - Self-selected - Nominated , specify - Others, specify			
5.A.7 Does the MoH disseminate information related to policy formulation and implementation to the public? Y/N			
5.A.8 Is dissemination done through: Can choose more than one answer: - Website - Media - Bulletins - Others, specify			
5.A.9 Did needs assessment was conducted as part of the policy formulation process? Siddiqi, 2009 Y/N			
5.A.10 Are the results of the assessment needs published? Y/N			
5.A.11 Does the MoH conduct public polls/surveys on regular basis to explore public preferences in relation to policy related to....? Y/N			
5.A.12 Is there a Hotline where people can call and give their opinions regarding policies? Y/N			
5.A.13 Is there any online platform for public to express opinions and give feedback? Y/N			
5.A.14 Are the public free to express their opinions through media? Y/N			
5.A.15 Is there in place a public relation operation/department to promote the MoH work regarding policies and receive feedback? Y/N			
OVERALL COMMENTS on Evidence Based Questions for RESPONSIVENESS:			

B. Perception Based Questions ***These questions will be asked to key informants through face-to-face interviews***	**Relevant / Not Relevant**	**Justifications**	**Need Editing Kindly Suggest Alternative**
5.B.1 Is the policy developed on.... responsive to the needs of the population? How?			
5.B.2 Was the policy developed in timely manner to respond to the needs of the population? Explain			
5.B.3 How the needs of the population were expressed/collected/measured?			
5.B.4 Does the MoH have the institutional capacity to collect/gather public preferences?			

And adapt to the conflicting needs?			
5.B.5 How does the MoH overcome the influence of professionals/elite groups over public opinion?			
5.B.6 What are the mechanisms that MoH can use to increase policy responsiveness? in terms of listening to the needs of the public and responding to their expectations			
5.B.7 How does the MoH overcome inequality in representations of the public?			
5.B.8 What is the importance of MoH being responsive to the public need in the policymaking process?			
5.B.9 What are the factors that can influence the responsiveness of MoH to the public needs in the policymaking process?			
5.B.10 How the public can express their opinions and give feedback regarding policies implemented?			
5.B.11 Does the MoH respond to media reports regarding failure to implement policies? How?			
5.B.12 What is the role of encouraging participation and promoting transparency on the responsiveness of the MoH to the public needs? Explain			
5.B.13 Do you consider MoH responsiveness a valid outcome of the governance process? Why?			
5.B.14 How can we measure/assess responsiveness of MoH?			
OVERALL COMMENTS on Perception Based Questions for RESPONSIVENESS:			

GENERAL COMMENTS:

Kindly Give reasons for choosing these sections of the tool to review:

Annex 5. List of Participants-Consultation Meeting

Egypt
Dr.Maha Rabbat
Executive Director MENA Health Policy Forum
Former Minister of Health

Dr. Sameen Siddiqi
Director,
Department of Health System Development
WHO-EMRO Office

Iran
Dr. AmirhosseinTakian
Deputy Acting Minister for International Affairs
Ministry of Health and Medical Education

Iraq
Dr.Salih Mahdi Al Hasnawi
Professor & Consultant Psychiatrist
Parliament Member
Former Minister of Health

Jordan
Dr. Hani Brosk Kurdi
Secretary General
High Health Council

Lebanon
Dr. Alissar Rady
National Professional Officer
WHO-Lebanon Office

Dr. Nabil Kronfol
Founder and President
Lebanese Health Care Management Association

Dr. Samer Jabbour
Associate Professor of Public Health Practice
Faculty of Health Sciences
American University of Beirut
Former-Staff of WHO

Dr.Walid Ammar
General Director
Ministry of Health

Morocco
Dr.AbdelhayMechbal
Health System, Health policy and Planning Consultant
Former-Staff of WHO

Switzerland
Dr. Maryam Bigdeli (via skype)
Health System Adviser
Department for Health Systems Governance & Financing
WHO-Geneva

United Kingdom
Dr Emma Kate Carmel (via skype)
Associate professor (Senior Lecturer)
Social and Policy Sciences
University of Bath

Annex 6. Summary of Results: Pilot

A. Summary of Evidence-based Question Analysis

Total Number of KIs is 11
Y: Yes, N: No, DK: Dont Know, P: In Progress

Participation	Answers per Number of KIs	Comments
Legal basis/requirement (Law/Regulation/Policy) to include various stakeholders in health policymaking process	Y:1, N:8, DK: 2	
If No law, A commitment to ensure some degree of stakeholders participation in formulation & implementation	Y:11	
A body or mechanism(s) was used to involve stakeholders in development of the **Mental Health Policy**	Y: 11	
A national committee	0	
An advisory Board	1	
Working Group (s)	7	KIs were confused about what to call the mechanism they were working in
Others	3	Task force, Focus group, Round table
Formally Formulated	7	KIs considered the invitation sent by email by the head of the program as a formal way to form the working group, which is not the case
A written scope/mandate for stakeholders involvement in the formulation of the **Mental Health Policy exists**	Y: 1, N:10	
Roles and the responsibilities of participants for the various stakeholders specified	Y: 3, N: 8	Who answered yes, said that it was mentioned verbally and not written
Qualifications of participants for the various stakeholders specified	Y: 4, N:6	Who answered yes, said it was not written though
Timetable for the work to be carried out set	Y: 7, N: 4	
The stakeholders represented in the FORMULATION of **Mental Health Policy**		
State Actors (Government, other than MoH, National, Local)	Y:6, N:1, DK:4	It means not all stakeholders were aware who are the others participating
Health Service providers	Y:10, DK: 1	
Parliamentary members	N:10, DK:3	
Beneficiaries (patients associations) &/or Public	Y:2, N:6, DK:3	
Civil Society	Y:11	
Development Partners/International organizations	Y:10, DK:1	
Funders/Financiers	Y:6, N:3, DK:2	Not all KIs were aware that the international

		organizations were funding the activities
Academic Institutions/Researchers	Y:10, N:1	
Private Sector (medical, pharmaceutical industry, insurance companies)	Y:2, N:7, DK:2	
Most Vulnerable or Key affected populations	N:10, DK:1	
Media	N:5, DK:6	
Participants involved in formulation of **Mental Health Policy** were selected:		
Appointed	5	
Elected	4	
Self-selected	0	
Representing Themselves	1	
Representing their organizations	10	It is important to know who they represent for accountability issues
Gender balance /consideration (Male vs. Female) among the stakeholders participating in the formulation of the **Mental Health Policy** was taken into account	Y:8, DK:3	There were more females than males
Dedicated resources made available by the MoH/Health Authority to enable participation during the development of **Mental Health Policy**, included	Y:10, N:1	
Cost of meetings	Y:9, DK:2	
Incentives for participants (Fee or Honoraria)	N:11	
Transportation and lodging (Direct Payment or Reimbursement)	N:11	
Documentation (Minutes of meetings) exist	Y:8, N:2 DK:1	
Final decisions were taken by participants:		
Majority Vote	0	
Consensus	8	
Other Procedures	2	Consultation and Brainstorming
Minutes published/made available to the public	N:9, DK:2	
Stakeholders involved in the IMPLEMENTATION of the **Mental Health Policy**		
State Actors (Government)	Y:9, N:1, DK:1	Most of KIs are not aware about the implementation phase
Health Service providers	Y:10, DK:1	
Beneficiaries (patients associations) &/or Public	Y:2, N:5, DK:3, P:1	
Civil Society	Y:9, DK:2	
Development Partners	Y:9, DK:2	
Academic Institutions/Researchers	Y:8, DK:3	
Private Sector (medical, pharmaceutical industry, insurance companies)	Y:8, N:1, DK:2	They were not involved in the formulation
Media	Y:7, N:2, DK:2	They were not involved in the formulation, yet they have a role in the implementation
Local Authorities/Community based organizations	Y:1, N:4,DK:5, P:1	
Roles and responsibilities of various stakeholders in implementation process specified	N:10, P:1	
Participatory body to oversee the implementation of the **Mental Health Policy**	Y:2, N:5, DK:4	Participation should be carried out

		throughout the policy making process
Mechanism/strategies used by MOH/Health Authority to ENCOURAGE participation by different stakeholders in health policymaking of **Mental health Strategy**		
Opinion Polls/Surveys	0	
Focus groups	0	
Public Hearings/Public Comments	0	
Online platforms	0	Although there is a council of minister decree abiding all ministries to public draft strategies/policies for at least 2 weeks on website to allow feedback and comments by the public, but not done
Citizens juries	0	
Roundtables	0	
Voting	0	
Hotline	0	
Inter-governmental conferences	0	
Policy dialogues	3	Done by academia and on a specific topic not on strategy

Accountability	Answers per Number of KIs	Comments
MoH/Health Authority require signature of contract/Memorandum of with various stakeholders before engaging them in		
Policy Formulation	N:7, DK: 4	
Policy Implementation	Y:6, N:2, DK: 3	MOUs are done but not with all stakeholders and not all are aware of this fact
Formal mechanism (s) followed by MoH/Health Authorities to hold public officials and non-state stakeholders involved in the policy formulation of the **Mental Health Policy** accountable based on their contribution for decisions and policies borne out in case of false advice/failure to engage in appropriate action	Y:1, N:8, DK: 2	No formal mechanism to hold various stakeholders accountable
Stakeholders are held accountable as		
Institutions/organizations represented	Y:10, N:1	
Type of the accountability mechanisms/types used by MoH/Health Authority to hold various stakeholders accountable		
Ethical	Y:10, DK: 1	
Professional/Performance	NA	
Legal	NA	
Financial	NA	
MoH/Health Authority conduct the following as part of holding its staff accountable for implementing the **Mental Health policy**		
Evaluation of the performance of the individual staff on annual basis	Y:2, N:1, DK:7, P:1	Stakeholders are not aware of such process takes place, this reflect lack of transparency
Administrative/Performance audit of the relevant department(s) on annual basis	Y:3, N:1, DK:5, P:1, NA:1	This reflects that stakeholders do not know what is happening internally
Financial auditing for personnel, operations, supplies, and others	NA	As all is based on funding from donors
Contracts oversight	Y:4, DK:6	It will be done based on MOUs signed
Formal mechanism (s) to hold implementing bodies of **Mental Health Policy** accountable in-line with set timelines and targets exist	Y:5, DK:6	
Internal within the health sector	Y:5, N:1, DK:5	Most stakeholders do not know
External by public	NA	
Accountability Mechanism (s)/types used by MoH/Health Authority at all levels include the following components:	NA	
Set Standards	NA	
Investigation & Answerability/Justifications	NA	
Sanctions	NA	

Enforcement	NA	
Rewards for Performance	NA	
Appeals	NA	
The following tools are used by MoH/Health Authority to foster accountability:		
Information System that generate key performance indicators	Y:7, N:, DK:3	
Dissemination of information	Y:9, DK:2	
Participation of Public/Civil organizations	Y:8, N:2, DK:1	
Whistle blowing mechanisms	Y:1, N:6, DK:3, P:1	
Watchdog organizations collaboration & Protection	Y:3, N:4, DK:4	
Performance incentives for good performance	Y:5, N:3, DK:3	Incentive only verbal appraisal of efforts done and visibility
Enforcement of rules & regulations	Y:5, N:4, DK:1, P:1	
Appeal mechanisms	N:8, DK:3	
Monitoring & evaluation (M&E) of **Mental Health Policy exist & include:**	Y:9, DK:2	
Compliance with **Mental Health Policy** by professionals/Private sector	Y:3, N:2, DK:5	
Policy outcomes in terms of health improvement, efficacy, equity and quality	Y:9, DK:2	
M&E process is formal	Y:6, DK:5	Stakeholders are not aware of the process, who is doing it and how often
M&E conducted independently	Y:2, N:4, DK:5	
Types of sanctions applied/might be applied to implementers and/or implementing bodies responsible for implementation of **Mental Health Policy** in case of violation/not adhering to standards set? Failure to implement	NA	
Legal Sanctions	NA	
Regulatory/Administrative Sanctions	NA	
Using Media: Name & Shame	NA	
Softer Sanctions	NA	
None is applied	Y:11	
Laws in place related to the **Mental Health Policy**	Y:9, N:1, DK:1	
Enforced	N:10, DK:1	
A plan to develop a new law	Y:11	

Transparency	Answers per Number of KIs	Comments
A law/mechanism that allow access by the general public to government information and documents	Y:1, N:3, DK:7	
A law/government policy in place to promote electronic government services to improve public access to government information and services	Y:2, N:3, DK:6	It is actually the government policy to simplify all administrative procedure and this include using electronic services, but people are not aware of it
Official website for the MoH/Health Authority	Y:11	
User-friendly	Y:10, DK:1	
Updated on regular basis	Y:8, DK:3	
Access to the website Open to all	Y:9, N:1, DK:1	
Decisions related to priority setting **in relation to the Mental Health Policy** made public	Y:10, N:1	
Decisions related to resource allocation **in relation to the Mental Health Policy** made public	N:10, DK:1	
Official, up-to-date (within last 5 years), detailed policy document regarding **Mental Health Policy**	Y:11	
Publicly available	Y:10, DK:1	
Easily accessible	Y:9, DK:2	
Available on the MoH/Health authority website	Y:9, DK:2	
Available in the official/national language of the country	Y:10, DK:1	
Document related to **Mental Health Policy** include the following information:		
Background on how the policy was formulated	Y:10, N:1	
Objectives, Purpose and goals based on priority problems	Y:11	
Evidence used to inform policy formulation	Y:8, N:2, DK:1	
Mechanisms to engage stakeholders participation	Y:6, N:5	Actually this is not mentioned
Stakeholders (Names & Affiliation) who participated/consulted in policy formulation	Y:11	
How decisions were made/Justifications for decisions	Y:3, N:7, DK:1	
Other factors that influenced the policy formulation: Specify:	Y:6, N:5	
Responsible body for releasing or approving the policy	Y:11	
Clear distribution of responsibility for implementation	N:11	
Contracting requirements for implementation if needed	N:11	
Time frame for implementation	Y:9, N:2	
Measurable Indicators & Targets	Y:10, N:1	Only targets are indicated but not indicators
Plans for monitoring & evaluation	Y:5, N:6	It is included but not all know about it
Funding requirements/allocation	N:10, DK:1	
Intended audience of the document	Y:5, N:5, DK:1	Actually it is not mentioned
Official publication (s) related to implementation of **Mental Health Policy** available:		
Five year strategic plan/Operational Plan	Y:4, N:1,	It is available but not

	DK:6	published
Program/Project Documents	Y:3, N:2, DK:6	
Relevant MoH/Health Authority decisions	Y:3, N:1, DK:7	
Progress reports	Y:5, N:2, DK:3, P:1	It is developed and shared but with some stakeholders NOT all
Financial reports including how funds were generated/secured for implementation/source of funding	N:4, DK:7	
Policy Evaluation	Y:2, N:1, DK:5, P:3	
Scientific Publications	Y:4, DK:5, P:2	There are few but not all are aware of it
Contracts made for implementation	N:2, DK:8, P:1	
Details about recruitment made to implement	Y:1, N:3, DK:7	
MoH/Health Authorities release information related to formulated and implemented policies in Periodic/regular manner	Y:5, N:5, DK:1	Not all stakeholders are receiving the progress reports/newsletters
Participants declared any conflict of interest by signing an official form	N:11	
A policy on conflict of interest management exist	N:11	
MoH/Health Authority is using or has used in the past 12 months, to INFORM/Disseminate to stakeholders (including the public) about policy formulation, development, implementation and progress of **Mental Health Policy**		
Use of mass media	Y:10, N:1	
Wide Advertisement	Y:5, N:6	
Bulletins	Y:6, N:5	
Targeted, Personal Invitations	Y:11	
Contact by email, Telephone, Mail	Y:10, DK:1	
Website	Y:10, DK:1	
Social media	Y:4, N:4, DK:3	
Smart Phones Applications	N:11	

Information	Answers per Number of KIs	Comments
MoH/Health Authority directly involved in the following in relation to policymaking:		
Information Generation	Y:9, N:1, DK:1	
Dissemination of health information	Y:10, N:1	
Publication	Y:7, N:3, P:1	
Knowledge Translation to policy	Y:5, N:1, DK:3, P:2	Actually this is not properly being conducted
MoH using:		
Data Collection tools	Y:8, N:1, DK:1, P:1	
Data Management technologies, specify:	Y:6, N:2, DK:1, P:2	
Validation of data sources	Y:3, N:3, DK:4, P:1	This is not being done
MoH/Health Authority have a form of partnership/collaboration with research centers	Y:8, DK:2, P:1	
MoH/Health Authority allocate funds in its yearly budget for research related to policy	N:5, DK:6	
MoH/Health Authorities make **Raw** data generated at health facilities/health service delivery level accessible to researchers	Y:2, N:4, DK:1, P:3, NA:1	
A specialized unit/staff in the MoH/Health Authority that deals with research analysis for policymaking exist	Y:3, N:4, DK:4	Not specialized in policy analysis
MoH/Health Authorities has a mechanism in place to check sources of funding of research to be used in policy	Y:2, N:4, DK:3, P:2	
Mental Health Policy was informed by scientific evidence	Y:11	
The scientific evidence used in policy formulation of the **Mental Health Policy**		
Reliable and of good quality source/Peer reviewed studies	Y:11	
Up-to-date (published in the last 5 years)	Y:9, N:2	Some national data are out of date but are the only available data
Comprehensive	Y:8, N:2, DK:1	
Locally Appropriate	Y:11	
Easily Accessible	Y:9, N:1, DK:1	
Global	Y:11	
National	Y:8, N:2, DK:1	
Local evidence	Y:7, N:2, DK:2	
Only Available evidence	Y:6, N:2, DK:3	
Other types of information utilized in the formulation of **Mental Health Strategy**		
Financial information	Y:3, N:4, DK:4	Financial issues were not taken

		into consideration
Governing laws	Y:8, N:1, DK:2	
Political direction & commitment	Y:5, N:3, DK:3	
Public Opinions	N:8, DK:3	
MoH/Health Authority publish periodic progress reports/M&E reports on policy implementation status of **Mental Health Policy**	Y:5, N:3, DK:3	Progress reports are produced but not disseminated to all, so not all are aware about it
Progress reports are disseminated Only to stakeholders	Y:6, DK:5	Not to all
Progress reports are disseminated Only to Public	N:11	
The following are used to disseminate:		
Printed material; flyers	0	
Public Presentations	0	
Website	0	
Emails	6	
Objectives of progress reports		
Increase awareness	Y:3, N:2, DK:6	Most do not know about the purpose of the progress reports are it is not clearly stated
Judge the situation/ Identify problems	Y:3, N:2, DK:6	Purpose is mainly to provide status of implementation and highlight activities
Provide evidence	Y:1, N:4, DK:6	
Assign responsibility	Y:1, N:4	

B. Summary of Perception Based Questions Analysis

Total Number of KIs is 8

Principle	Thematic Analysis
Participation	- MoH/Mental Health Team started a new initiative to involve all in strategy formulation, keen to involve all - Still Not full participation - Things are not structured, process not well defined - Need more infrastructure, resources, experienced staff and capacity - External funding which makes things not sustainable - All felt involved, and are supportive - Final decisions were based on consensus - It was an effective, inclusive process, but service users were excluded - Participants were representatives and qualified group; they were asked to join via an informal process using personal contacts and professional networks - Invitations to join were sent via email - Everyone identified a different powerful stakeholder, but all agreed that their role was facilitating -Stakeholders need to be involved in the implementation planning as well even if they do not have a direct role - Facilitators of the process included: leadership of the mental health team and the way discussions were handled, all stakeholders were motivated, almost all stakeholders knows each other. - Barriers to the process included: finding the right time and place for the meetings, was not an easy task to agree on same agenda, terminologies, etc, information given before the meeting was not enough - No coordination at the implementation - There were two consultation meetings (round table discussions) and follow up was done by email
Accountability	- It is important to hold all stakeholders accountable, but hard to do so, and cannot hold them for something not clear - There was no evaluation or a process to assess feedback of stakeholders - Accountability is a cultural issue - Accountability issues need to be formalized and follow standardized practices - Watchdogs are needed and participation is also important as it generated good results - Media has a big/important/positive role in accountability, but they need to be sensitized and trained, and a toolkit for media is needed - NGOs has also a big and active role to put pressure on MoH and to implement policies - The public they do not have a role in holding the government accountable, they are not aware of this right, they need proper mechanisms to express their opinions - No clear idea about how to hold everyone accountable and enforce it - Enforcement of the law is an issue, MoH should be responsible for its implementation - Even if there is a good law, failure to implement comes due to lack of inclusion of all stakeholders especially who will be the most affected - No information about the internal process of MoH for accountability - Accreditation for mental wards in hospitals is a tool for accountability
Transparency	- The process was transparent, but not enough and not full transparency - Transparency can burden the process - Need to publish more documents on regular basis and make them available on the website, given that the documents are useful and short and there is a need to have regular discussions of problems that emerge - Documentation is an important issue and the process should be standardized and it needs commitment - Opinions of stakeholders should be disclosed since there is conflicting priorities and competing needs - The process was transparent to stakeholders but not to the public - Stakeholders were informed on regular basis on the development process not on

	implementation plans - The strategy document is comprehensive enough and user friendly but it is not made for the public as it contains scientific terms. The document lacks implementation and costing plans and lacks needs assessment - Priorities setting process was not transparent, as the national team suggested the priorities and consensus followed and there were no justifications for the goals set - Roles and responsibilities of the various stakeholders are not defined and not transparent, there is a lack of planning for the implementation
Information & Intelligence	- The MoH is committed to use evidence based in policy formulation, as the Mental health strategy was developed based on studies and statistics - All staff are qualified to access and use research based on their technical background (all are Master degree holders) - There is a close relationship with academia with regular discussion, but no funding is available - Mainly it was based on expert opinion and based on feedback from stakeholders working in the field - There is weak national evidence on mental health as no local data, no up-to-date prevalence data - Factors that influenced the development of the mental health strategy in addition to evidence base include: availability of funding from international donors, the Syrian refugees crisis and their influx to Lebanon, interest of stakeholders to work on this strategy and the recommendations of UN agencies including WHO
Responsiveness	- There is no capacity for MoH to collect public needs and opinions - This needs networking with people, a survey can be done, NGOs working in the field with beneficiaries can help in this, also opening a space at the website and ask people to comment is a good idea - The factors that can influence the responsiveness of the MoH to public needs include: availability of resources, political implications, security and safety of staff, the leadership from the community and the flexibility of the administration - It is important to listen to all needs without taking sides, be open and fair, and coordinate between competitors, till a decision mature. - Need communication and advocacy strategies to target both levels; community and professionals - Need to empower people and increase awareness - The strategy is not patient centres as their opinions were not taken, but it is based on ethics and values based on pyramid of services, it was developed as a top bottom approach. - It highlights the importance of respect to patients and autonomy to empower patients - Mental health was not a priority and there were a lot of challenges; lack of resources, lack of updated evidence, and there was no national program or team, all of this caused delay in issuing a national strategy. - Even in the absence of a strategy, the MoH was providing services (medications and hospitalizations) - The Syrian crisis and the creation of a national program fasten the process to set a national strategy

C. Summaries of Findings Per Principle & Characteristics

Principle	Characteristics	Summary of the Findings
Participation	- Legal framework	- There is no legal requirement to include various stakeholders in health policymaking
	- Not all types of participants were involved	- No participation of parliamentary members, the private sector or patient groups
	- Institutional official structure	- There was a working group but not officially established
	- SOPs	- No mandate for the committee; roles, responsibilities and qualifications are not specified
	- Financial Resources	- No incentives were given for participation, but meeting costs were secured
	- Transparency	- Minutes of meetings are documented but not published
		- Role and the responsibilities of the implementation bodies were not set within the strategy
	- Consensus orientation	- Decisions were taken by consensus
	- Mechanisms used to enhance participation	- No strategies were used to encourage participation like opinion polls, focus groups, online platforms, etc
	- Participatory body to oversee implementation	- No participatory body was established to oversee the implementation of the strategy
		- No coordination regarding the implementation
	- Financial Resources & contextual factors	- Implementation will rely on external funding which will not be sustainable
	- Barriers of participation	- Barriers to the process included: finding the right time and place for the meetings, was not an easy task to agree on same agenda, terminologies, etc, information given before the meeting was not enough
	- Leadership	- There is commitment of the national team to involve all in strategy formulation
	- Facilitators of participation	- Facilitators of the process included: leadership of the mental health team and the way discussions were handled, all stakeholders were motivated, almost all stakeholders knew each other
Accountability	- MOUs	- Stakeholders did not sign any MOU before their engagement in the policy formulation process
	- Formal mechanisms for accountability	- No formal mechanisms in place to hold public officials and non-state stakeholders involved in the policy formulation accountable
	- Types of accountability	- Most used type of accountability is ethical, while others like legal, performance and financial are not enforced
	-Internal accountability	- MoH has an internal process to hold its staff responsible for implementation accountable using evaluation of performance, administrative audit and contacts oversight, but result of those are not published
	- External accountability by external	- No external independent audit takes place nor is accountability by the public practised

	- Components of accountability	- All components of accountability are not in place: standards, investigation mechanisms, sanctions, enforcement nor appeals
	- Mechanism to foster accountability	- MoH is involved in generating key performance indicators and dissemination of information - There are no mechanisms for whistle blowing and watchdog protection
	- Performance accountability	- Monitoring and evaluation (M&E) plans do not include evaluation for the compliance of the private sector when implementing the strategy
	- Types of sanctions	- There are no set sanctions (legal, regulatory, softer sanctions) applied in cases of violation or failure to implement
	- Rule of law	- Current law about mental health is not enforced and there are plans to amend it
	- Role of media	- Media has an important role in accountability, but they need to be sensitised and trained, and a toolkit for them is needed
	- Role of NGOs	- NGOs also has a big and active role to put pressure on MoH and to implement policies
Transparency	-Laws	- There is no law in place to allow access to government information by the public
	- E-transparency	- There is an official website that is updated, user friendly and is accessible to all public
	- Transparency in priority setting &resource allocation	- Decisions related to priority setting are made public - Priorities setting process was not transparent, as the national team suggested the priorities and consensus followed and there were no justifications for the goals. Priorities setting process was not transparent, as the national team suggested the priorities and consensus followed and there were no justifications for the goals set
	- Documentation of policy	- Decisions related to resource allocation are not made public - There is an official document about the strategy that is updated, publicly available, placed on website, and is available in the national language of the country, which is Arabic - The strategy documents include the following: Background on how the policy was formulated, objectives, purpose and goals based on priority problems, evidence used, stakeholders who were involved, responsible body for releasing the strategy, timeframe for implementation, and plans for M&E. - The strategy documents do not include: mechanisms used to engage the stakeholders, justifications for decisions that were made, clear distributions of responsibilities for implementation, funding requirements and intended audience of the document
	- COI declaration	- Participants did not declare any conflict of interest before being engaged in the consultation process of developing the strategy
	- Release of governments decisions	- There are no official documents related to the five year strategic plan, relevant implementation decisions, financial reports, contracts made for implementation nor details about recruitment made to implement
	- Dissemination channels	- MoH disseminated information about the strategy using mass media, newsletters, personal invitations, emails, and website
	- Negative aspects of	- Transparency can burden the process

	transparency - Full transparency vs. partial	 - Documentation is an important issue and the process should be standardised as well as needing commitment - Opinions of stakeholders should be disclosed since there are conflicting priorities and competing needs - The process was transparent to stakeholders but not to the public - Stakeholders were informed on regular basis on the development process, but not on implementation plans - The strategy document is comprehensive enough and user friendly, but it is not made for the public as it contains scientific terms - Roles and responsibilities of the various stakeholders are not defined and not transparent, there is a lack of planning for the implementation
Information & Intelligence	- Generation of information - Stakeholders relationships - Institutional capacity - Institutional capacity - Mechanisms to check sources of funding - Evidence-based approach - Other types of information used - Dissemination of information - Factors affecting use of information	- MoH use data collection tools like registries, surveys and other statistics and data management tools - MoH collaborates with research centres in the country, but there is no allocation of a budget for research - MoH has no specialised unit that deals with research analysis for policymaking nor making raw data generated at the service delivery level accessible to researchers - All staff are qualified to access and use research based on their technical background (all are masters degree holders) - There is no mechanism in place to check sources of funding nor validate data sources - The strategy was informed by scientific evidence that was up to date, reliable and of good quality, comprehensive and locally appropriate - Other types of information that influenced the strategy included existing laws and political will and commitment, while financial information and public opinion were not taken into consideration - Progress reports and M&E reports are generated but not published and are only shared with some stakeholders by email - Factors that influenced the development of the mental health strategy in addition to evidence base included: availability of funding from international donors, the Syrian refugees crisis and their influx to Lebanon, interest of stakeholders to work on this strategy and the recommendations of UN agencies including the WHO
Responsiveness	- Adequate health services - Respect for dignity & confidentiality - Adequate basic services and prompt attention	- The strategy ensures that all will have access to quality services including disadvantaged/vulnerable groups - The strategy ensures that all health services related to mental health will respect the confidentiality and dignity of all - The strategy does not explicitly state the benefit package to be provided, how referral will take place from one level of care to another nor does it provide a reasonable timeframe to deliver the

		services needed
	- Assessments of public preferences and satisfaction	- Needs assessment was not conducted as part of the strategy formulation process - The strategy did not set out that patient satisfactory surveys should be conducted
	- Rights &responsibilities	- The strategy mentions only the rights of the patients and not their responsibilities
	- Institutional capacity	- There is no capacity for the MoH to collect public needs and opinions
	- Factors that affect responsiveness of the government	- The factors that can influence the responsiveness of the MoH to public needs include: availability of resources, political implications, security and safety of staff, the leadership from the community and the flexibility of the administration
	- Contextual factors	- The Syrian crisis and the creation of a national programmewas speeding up the process to set a national strategy

Annex 7. Final Tool

Health Policymaking-Governance Guidance Tool (HP-GGT)

HP-GGT is a Generic Tool

Key Informants Information Date:

KI number:

Gender:

KI works in:

- Government (Public Sector)
- Private Sector
- Non-governmental organization
- International organization
- Academia
- Media
- Other (please specify):

Agreed for second interview: Yes No

SECTION A: Evidence-Based Questions

I: PARTICIPATION at policymaking level

Everyone should have a voice in decision-making for health, either directly or through legitimate intermediate institutions that represent their interests. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively. It is about empowering citizens to have a role in decisions that affect their lives, and reach common goals by participating in policymaking process. It is the responsibility of the government to create mechanisms and spaces for participation.

Y: Yes, N: No, P: In Process, D.K.: Don't Know, N.A: Not Applicable

	Participation **Evidence Based Questions;** ***Answers for these questions will be collected through face-to-face interviews with KIs and answers to be validated by documented evidence***					
I. A.1	Is there a Legal basis/requirement (Law/Regulation/Policy) to include various stakeholders in health policymaking process? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes, Specify what is it?					
	& in what phase of the policymaking process is it specified to consult with stakeholders *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	In policy formulation					
	In policy implementation					
	Other, Specify:					
	Not Specified					
	If No, is there still a commitment from the MoH/Health Authority/National Program to ensure some degree of stakeholders participation in formulation & implementation of national health policies? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
I.A.2	Was there a body or mechanism(s) used to involve stakeholders in policymaking process that was concerned with the development of the **X Policy**? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes, what body or mechanism (s) was used to involve stakeholders in the policymaking process that was concerned with the **X Policy**? *(Assessor: Read each response option, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	A national committee					
	An advisory Board					
	Working Group (s)					
	Other, Specify:					
	How was this body /mechanism (mentioned above) formulated? *(Assessor: Read each response option, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Formally (in written format), Specify How & By Whom:					
	Informally, Specify How:					
	If it was Formally formulated,					
	Was there a written scope/mandate for stakeholders' involvement in the formulation of the **X Policy**? What is the scope/mandate for the stakeholders?	Y	N	P	DK	NA
	Were the roles and the responsibilities of participants for the various stakeholders specified?	Y	N	P	DK	NA

	Were the qualifications of participants for the various stakeholders specified?	Y	N	P	DK	NA
	Was there a timetable for the work to be carried out?	Y	N	P	DK	NA
I.A.3	Were the following stakeholders represented in the FORMULATION that was concerned with **X Policy?** *(Assessor: Read each response option, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	State Actors (Government, other than MoH, National, Local): Specify:					
	Health Service providers (Professional Association/Unions/Orders & Health Service Organizations/Hospital boards) Specify:					
	Parliamentary members					
	Beneficiaries (patients associations) &/or Public: Specify:					
	Civil Society: Specify:					
	Development Partners/International organizations: Specify:					
	Funders/Donors: Specify					
	Academic Institutions/Researchers: Specify:					
	Private Sector (medical, pharmaceutical industry, insurance companies): Specify:					
	Most Vulnerable or Key affected populations: Specify:					
	Media					
	Others: Specify:					
	Were representatives from local/regions within X Country represented? How?	Y	N	P	DK	NA
I.A.4	For each category of stakeholders identified above, how were the participants involved in formulation of **X Policy** selected? *(Assessor: Read each response option, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Appointed, Nominated was there a set criteria for the selection?					
	Elected, by whom?					
	Self-selected					
	Others:					
	Was their participation:					
	Voluntary					
	Mandatory					
	Are participants: *(Assessor: Read each response option, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Representing Themselves: Specify:					
	Representing their organizations: Specify:					
	Other, Specify:					
I.A.5	Is there a gender balance /consideration (Male vs. Female) among the stakeholders participating in the formulation of the **X Policy?** *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
I.A.6	Are there dedicated resources made available by the MoH/Health Authority to enable and facilitate participation during the policy development process of **X Policy**? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes, what type of resources is made available? *(Assessor: Read each response option, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Cost of meetings (venues, coffee breaks, etc)					
	Cost of Administrative work (print outs, etc)					
	Incentives for participants (Fee or Honoraria): Specify:					

	Transportation, lodging and/or meals (Direct Payment or Reimbursement): Specify:					
	Other, Specify:					
I.A.7	Is there documentation (Minutes of meetings) on the recommendations submitted for final decisions in relation to the formulation of the **X Policy**? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	Are the minutes published/made available to the public? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
I.A.8	How final decisions were taken by participants: *(Assessor: Read each response option, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Majority Vote					
	Consensus					
	Dissenting Opinions					
	Other Procedures					
	Not Specified					
	Is there documentation of this?	Y	N	P	DK	NA
I.A.9	Are the roles and responsibilities of the various stakeholders in the implementation process specified in the formulation document of the **X Policy**? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If NO, are they defined by law or by any other formal means?	Y	N	P	DK	NA
I.A.10	Is there a participatory body to oversee the implementation of the **X Policy**? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes, What is its composition?					
I.A.11	Are other mechanism/strategies used by MOH/Health Authority/National Program to ENCOURAGE participation (express opinions/preference and encourage feedback) of different stakeholders in priority setting and in policymaking process of **X Policy**? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If YES, which mechanisms are used *(Assessor: Read each response option, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Opinion Polls/Surveys					
	Focus groups					
	Public Hearings/Public Comments/Citizens Juries					
	Online platforms					
	Voting					
	Hotline					
	Inter-governmental conferences					
	Policy dialogues					
	Others, specify:					

II. ACCOUNTABILITY at policymaking Level

Is about assuring that those who are responsible for designing and implementing policies are held accountable for their performance. Decision-makers in government, the private sector and civil society organizations involved in health are accountable to the public, as well as to institutional stakeholders. This accountability differs depending on the organization and whether the decision is internal or external to an organization. It is about having the right checks and balances put into place. It is ensuring that all health system actors are held publicly accountable .

Y: Yes, N: No, P: In Process, D.K.: Don't Know, N.A.: Not Applicable

	Accountability **Evidence Based Questions; *Answers for these questions will be collected through face-to-face interviews with KIs and answers to be validated by documented evidence***	Y	N	P	DK	NA
II.A.1	Does the MoH/Health Authority/National Program require signature of contract/Memorandum of understanding/Terms of Reference (that include incentives, sanctions, timeline, deliverables, etc) with stakeholders before engaging them in: *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Policy Formulation					
	Policy Implementation					
II.A.2	Are the different stakeholders (public officials & non-state actors) involved in the policy formulation related to **X Policy** formally held accountable for their contribution for decisions and policies in case of false/bad advice/failure to engage in appropriate action? *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	To their institutions/organizations					
	To the public					
	If Yes, who are the stakeholders held accountable from within institutions/organizations they represent in policy formulation? *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Governmental Staff					
	Professionals					
	Private Sector					
	NGO Representatives					
	All					
	Others: Specify					
II.A.3	What is the type of the accountability mechanisms/types used by MoH/Health Authority/National Program and various institutions/organizations involved in policy towards their representatives? * *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Ethical					
	Professional/Performance					
	Legal					
	Financial					
	Others, Specify:					
II.A.4	Does the MoH/Health Authority/National Program conduct any of the following as part of holding its staff accountable for their role in implementing the **X Policy**?					

	(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)					
	Evaluation of the performance of the individual staff on annual basis					
	Administrative/Performance audit of the relevant department(s) on annual basis					
	Financial auditing for personnel, operations, supplies, and others					
	Contracts oversight					
	Are the results of the above made public?	Y	N	P	DK	NA
II.A.5	Are any of the following tools used by MoH/Health Authority to foster accountability?** *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Information System that generate key performance indicators					
	Dissemination of information					
	Participation of Public/Civil organizations					
	Whistle blowing mechanisms					
	Watchdog organizations collaboration & Protection					
	Performance incentives for good performance					
	Enforcement of rules & regulations					
	Others, Specify:					
II.A.6	Is there monitoring & evaluation (M&E) of implementation of **X Policy?** *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes, does the M&E include the following: *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Compliance with **X Policy** by professionals/Private sector					
	Policy outcomes in terms of health improvement, efficacy, equity and quality					
	None					
	Are the results made public?	Y	N	P	DK	NA
II.A.7	**If Question II.A.6 is YES,** Is the M&E process formal? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes,					
	Is the M&E conducted independently, by whom:	Y	N	P	DK	NA
	How often M&E take place?					
II.A.8	Did the MoH/Health Authority/National Program set a formal mechanism (s) to hold implementers and/or implementing bodies from the private sector/non-state actors responsible for implementation of various components of **X Policy** accountable in-line with set timelines and targets? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes, Are the following components set? ? *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Standards (accreditation, benchmarking, rules and procedures, guidelines, etc) , Specify:					
	Investigation & Answerability/Justifications Mechanisms					
	Sanctions					
	Enforcement Mechanisms					
	Rewards for Performance					
	Independent Appeal Mechanisms					

II.A.9	**If Question II.A.8 is Yes,** Who is authority responsible for holding implementers and/or implementing body accountable? *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Internal within the health sector, Specify:					
	External by independent bodies, Specify					
	External by public: Specify:					
	Others: Specify:					
	Are the results of the above made public?	Y	N	P	DK	NA
II.A.10	What are the types of sanctions applied/might be applied to implementers and/or implementing bodies responsible for implementation of **X Policy** in case of violation/not adhering to standards set? Failure to implement? *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Legal Sanctions					
	Regulatory/Administrative Sanctions					
	Using Media: Name & Shame					
	Softer Sanctions, Specify:					
II.A.11	Are there any law*(Assessor: Read the response options and Circle the answer given by the Key Informant)*s in place related to the **X Policy**? What does the law(s) cover?	Y	N	P	DK	NA
	If Yes, is it enforced? How? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	Is there a plan to develop a new law? Why? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA

* If the answer to this question is Not Applicable, you can formulate the question as follows: What is the most suitable accountability mechanism/type that can be applied to hold the various stakeholders accountable in their role in the context of your country?

** If the answer to this question is Not applicable, you can formulate the question as follows: What of the following tools is best to be used to foster/encourage accountability in the context of your country?

III. TRANSPARENCY at the Policymaking Level

It is actively disclosing information on how decisions are made, implemented and evaluated. It is built on the free flow of information for all health matters. Processes, institutions, and information should be directly accessible to those concerned with them, and enough information is provided to understand and monitor health.

Y: Yes, N: No, P: In Process, D.K.: Don't Know, N.A.: Not Applicable

	Transparency **Evidence Based Questions;** ***Answers for these questions will be collected through face-to-face interviews with KIs and answers to be validated by documented evidence***					
III.A.1	Is there a law/mechanism about "access to information" that allow access by the general public to government information and documents? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes, Does the law allow: *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Full Access					
	Partial Access/Restricted Access					
	Access to Information on Health					
III.A.2	Is there a law/government policy in place to promote "cyber transparency"(availability of information online) electronic government services to improve public access to government information and services? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
III.A.3	Is there an official website for the MoH/Health Authority? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes,					
	Is it user-friendly?	Y	N	P	DK	NA
	Is it updated on regular basis/has up to date news, documents, etc?	Y	N	P	DK	NA
	Is access to the website open to all?	Y	N	P	DK	NA
	If No, Why? who is allowed to access it?					
III.A.4	Are decisions related to priority setting in relation to the **X Policy** made public? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	How?					
III.A.5	Are decisions related to resource allocation (general resource allocation decisions, focused on overall budgets) in relation to the **X Policy** made public? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	How?					
	Are the Cost estimates clearly explained and justified?	Y	N	P	DK	NA
III.A.6	Is there official, up-to-date (within last 5 years), detailed policy document regarding **X Policy**? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes, Is it:					
	Publicly available?	Y	N	P	DK	NA
	Easily accessible?	Y	N	P	DK	NA

	Available on the MoH/Health authority website?	Y	N	P	DK	NA
	Is the document available in the official/national language of the country? What other languages is it available?	Y	N	P	DK	NA
III.A.7	Does the document related to **X Policy** include the following information: *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Background on how the policy was formulated (based on international guidelines, best practices, etc)					
	Objectives, Purpose and goals based on priority problems					
	Evidence used to inform policy formulation					
	Mechanisms to engage stakeholders participation					
	Stakeholders (Names & Affiliation) who participated/consulted in policy formulation					
	How decisions were made/Justifications for decisions					
	Other factors that influenced the policy formulation: Specify:					
	Responsible body for releasing or approving the policy					
	Contracting requirements for implementation if needed					
	Time frame for implementation					
	Measurable Indicators & Targets					
	Plans for monitoring & evaluation					
	Funding requirements/allocation (including costs of human resources, medicines, management, infrastructure and costs for activities and stakeholders beyond the public health sector)					
	Intended audience of the document					
III.A.8	Is there plans to publish/already published any of the following documents that are related to implementation of **X Policy**? *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Five year strategic plan/Operational Plan/Implementation Plans					
	Program/Project Documents					
	Relevant MoH/Health Authority decisions					
	Policy Evaluation Reports					
	Financial reports including how funds were generated/secured for implementation/source of funding					
	Scientific Publications					
	Contracts made for implementation					
	Details about recruitment made to implement					
	Others: Specify					
III.A.9	Does the MoH/Health Authorities/National Program release information related to formulated and implemented X policy in "predictable manner"/Periodic/regular manner? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
III.A.10	Did participants declared any conflict of interest by signing an official form? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*					
	In the policy formulation	Y	N	P	DK	NA
	In the policy implementation	Y	N	P	DK	NA
	If Yes, Is there a policy on conflict of interest management?	Y	N	P	DK	NA
	Who is responsible for the oversight on conflict of Interest?					

III.A.11	Which of the following methods, if any, the MoH/Health Authority/National Program is using or has used in the past 12 months, to INFORM/Disseminate to stakeholders (including the public) about policy formulation, development, implementation and progress of **X Policy**? *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Use of Mass Media (TVs, Radios, etc)					
	Wide Advertisement (Newspapers, Billboards, etc)					
	Bulletins/Newsletters					
	Targeted Personal Invitations by email, mail, Telephone, etc..					
	Social Media					
	Smart Phones Applications					
	Others, specify:					

IV. USE OF INFORMATION at the policymaking Level

Is essential for a good understanding of health system without which it is not possible to provide evidence for informed decisions that influences the behavior of different interest groups that support, or at least do not conflict with, the strategic vision for health. It includes; information generation, collection, analysis and dissemination. Sound and reliable information is essential for health system policy development and implementation, governance and regulation. Availability of information includes accessibility, user-friendly, comprehensiveness and completeness.

Y: Yes, N: No, P: In Process, D.K.: Don't Know, N.A.: Not Applicable

	Information **Evidence Based Questions; *Answers for these questions will be collected through face-to-face interviews with KIs and answers to be validated by documented evidence***					
IV.A.1	Is the MoH/Health Authority/National Program directly involved in the following in relation to policymaking: *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Information Generation					
	Dissemination of health information, Specify type of information disseminated:					
	Publication, Specify types of publications:					
	Knowledge Translation to policy					
IV.A.2	Is the MoH/Health Authority/National Program using any of the following? *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Data Collection tools (vital registries, surveys (population, facilities, etc), health statistics), Specify:					
	Data Management technologies, Specify:					
	Validation of Data sources					
	Checking sources of funding of research to be used in policy					
IV.A.3	Does the MoH/Health Authority/National Program have any form of partnership/collaboration with research centers inside as well as outside the country? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes, Does the MoH/Health Authority/National Program allocate funds in its yearly budget for research related to policy?	Y	N	P	DK	NA
IV.A.4	Does MoH/Health Authorities make **Raw** data generated at health facilities/health service delivery level accessible to researchers? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
IV.A.5	Is there a specialized unit/staff in the MoH/Health Authority/National Program that deals with research analysis for policymaking? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
IV.A.6	Was the developed **X Policy** informed by scientific evidence? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
IV.A.7	**If Questions IV.A.6 is YES,** Which of the following criteria were used for the inclusion of scientific evidence in policy formulation of the **X Policy?** *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Reliable and of good quality source/Peer reviewed studies					

	Up-to-date (published in the last 5 years)					
	Comprehensive/Extensive					
	Locally Appropriate					
	Easily Accessible					
	Global/International					
	National					
	Local Evidence/Community level					
	Only Available evidence					
IV.A.8	Were other types of information utilized in the policy formulation of **X Policy**, Like: *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Experts opinion					
	Financial information					
	Governing laws					
	Political direction & commitment					
	Others, Specify:					
IV.A.9	Does the MoH/Health Authority/National Program publish/plan to publish periodic progress reports/M&E reports on policy implementation status of **X Policy**?	Y	N	P	DK	NA
	If Yes, Does progress reports include: *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Follow Up Plans					
	Impact of the policy					
	Recommended review of the policy considering results obtained					
	If Yes, Are the progress reports disseminated?	Y	N	P	DK	NA
	If Yes, is it disseminated to					
	Public					
	Only for stakeholders					
	What media/means are used to disseminate the results?					
	Printed material					
	Public Presentations					
	Website					
	- Others, Specify					
IV.A.10	**If Questions IV.A.10 is YES,** What are the objectives of progress reports? *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Increase awareness					
	Evaluate the situation					
	Identify problems					
	Provide information					
	Assign responsibility					

V. RESPONSIVENESS TO POPULATION NEEDS at the policy making level

Institutions and processes should try to serve all stakeholders to ensure that the policies and programs are responsive to the health and non-health needs of its users. Governments are obliged to listen to the needs of their citizens and act on their concerns, and respond to their expectations. It is not only about "Clinical" Responsiveness.

	Responsiveness **Evidence Based Questions;** ***Answers for these questions will be collected through face-to-face interviews with KIs and answers to be validated by documented evidence***	Y	N	P	DK	NA
V.A.1	Does the **X Policy** include an objective/goal that MoH/Health Authority/National Program will ensure access to adequate **Quality** of care services to ALL the population/patients including disadvantaged/vulnerable groups to be covered by the policy? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
V.A.2	Does the **X Policy** include an objective/goal that the health services will respect the confidentiality and the dignity of the population/patients? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
V.A.3	Does the **X Policy** include an objective/goal that the health providers will respect the rights of the patients in terms of: *(Assessor: Read the response options, allow Key Informant to reply, and check by adding (√)all options that Key Informants identifies)*					
	Autonomy to participate in health related decisions					
	Freedom of choice of health care provider					
	Provide all information related to the patients' medical conditions in an understandable manner					
	Others: Specify:					
V.A.4	Does the **X Policy** refer to the explicit package of benefits to be provided to patients at the different levels of care? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
V.A.5	Does the **X Policy** include an objective/goal that the health services will be provided to population/patients within reasonable timeframe? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes, is the timeframe specified?	Y	N	P	DK	NA
V.A.6	Does the **X Policy** refer to how referral of patients will take place from one level of care to the other? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes, is the timeframe for referral specified?					
V.A	Does the **X Policy** include an objective/goal to set in place an official	Y	N	P	DK	NA

.7	complaint mechanism? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*					
V.A .8	Was a needs assessment (targeting the public)/Public Opinion surveys conducted as part of the **X Policy** formulation process? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes, Is there evidence that the identified population needs were incorporated in the **X Policy**?	Y	N	P	DK	NA
V.A .9	Do the monitoring & evaluation plans of the **X Policy** include a component to assess whether the policy is meeting the population needs through conducting patients satisfaction surveys/exit surveys? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA
	If Yes, is it recommended to be done on regular basis?	Y	N	P	DK	NA
V.A .10	Did the MoH/Health Authority/National Program develop a communication strategy to inform the public about the X Policy? *(Assessor: Read the response options and Circle the answer given by the Key Informant)*	Y	N	P	DK	NA

SECTION B: Perception-based Questions

I. Participation at the policymaking level

	Participation **KI Interviews Questions;** ***These questions will be asked to key informants through face-to-face In-depth interviews***
I.B.1	How do you view the role of MoH/Health Authorities/National Program in encouraging stakeholders' participation in policy formulation and implementation in general? & in the **X Policy** development in specific? Does the MoH/Health Authority/National Program has the institutional capacity and needed resources to facilitate the participation process? In terms of leadership? Planning? Needed information? Institutional arrangements? Database of key stakeholders?
I.B.2	To what extent was the formulation process of the **X Policy** inclusive of the key stakeholders? Were they "Effectively "consulted**?** Were all relevant voices taken into account? Which stakeholders were missing?
I.B.3	What type of process was applied for the selection/identification of participants in the **X Policy** formulation? Do You consider that it was a fair/effective process to ensure a qualified group? A representative group? Why?
I.B.4	Who were the powerful stakeholders in the decision making/formulation of the **X Policy**? Was their influence hindering or facilitating the formulation process of **X Policy**? What their influence led to?
I.B.5	What are the barriers and/or facilitators to the participatory process? For MoH/Health Authorities/National program? For stakeholders?
I.B.6	What are the mechanisms used to enable stakeholder participation in policymaking process? Do they include mechanisms to give voice to the traditionally voiceless groups (homeless, migrants/refugees, unemployed, minorities, disabled, elderly, etc?? How do you view the effectiveness of these mechanisms?

II. Accountability at the policymaking level

	Accountability **KI Interviews Questions;** ***These questions will be asked to key informants through face-to-face in-depth interviews***
II.B.1	To what extent do you agree that all stakeholders should be held accountable for their role in the policymaking process including formulation? What is the best way to hold the various stakeholders accountable for their role in policymaking? How to ensure that they know they will be held accountable prior to their involvement?
II.B.2	What is the role of media in accountability in policymaking in your setting? Is media playing a positive or negative role in **Policy X**? Give examples
II.B.3	Does the civil society have an active role as watchdogs over policy formulation and implementation of **Policy X**? How? Give examples
II.B.4	How the public can hold various stakeholders accountable for their role in policymaking in general and in relation to **Policy X**?
II.B.5	How the implementing bodies are held accountable for their roles in the policy implementation process of **X Policy**? Are all held accountable in equal manner? Give examples
II.B.6	How is the law (s) related to **X Policy** translated into rules, regulations and procedures? Who is responsible for this? How does the MoH/Health Authority/National Program ensure that regulations, legislations and sanctions are fairly enforced in relation to the implementation of the **X Policy** in both public and private sector?

III. Transparency at the Policymaking level

	Transparency **KI Interviews Questions;** ***These questions will be asked to key informants through face-to-face in-depth interviews***
III.B.1	Does the MoH/Health authority/National Program have the interest/willingness/Commitment to achieve better transparency? What is the type of this willingness/commitment? How can the MoH/Health Authority/National Program increase its transparency in the policymaking process? Does the MoH/Health Authority/National Program have the needed capacity/means to achieve better transparency?
III.B.2	How the MoH/Health Authorities/National Program can ensure that the opinions of the different stakeholders are documented & disclosed/published as part of a transparent policymaking process?
III.B.3	How transparent was the policy formulation process of **X Policy** as perceived by stakeholders? by public? What made it transparent? What could have been done to make it more transparent?
III.B.4	How comprehensive is the **X Policy?** Is the policy document user-friendly& easily accessible? How useful? What is missing?
III.B.5	How transparent was the process of priority setting during the development of **X Policy**? How this process can be improved?
III.B.6	How transparent is/was the process of resource allocation for implementing the **X Policy**? Are criteria applied for allocating resources known to all?

IV. Information at the policymaking level

	Information **KI Interviews Questions;** ***These questions will be asked to key informants through face-to-face in-depth interviews***
IV.B.1	How committed is the MoH/Health Authority/National Program leadership to use evidence-based (scientific evidence) and other types of information in policymaking process? What is the evidence for this commitment? Is it documented?
IV.B.2	How can the capacity of staff at the MoH/Health Authority/National Program be improved in terms of to access/use and analysis of research evidence?
IV.B.3	Can you describe the relationship between MoH/Health Authority/National Program leadership and researchers? Is their regular interaction?
IV.B.4	Do you consider the scientific evidence used in the formulation of **X Policy** pertinent/adequate? Why? What factors influenced the uptake of evidence-based/research findings into **X Policy**? What additional evidence would have been necessary?
IV.B.5	How national evidence is generated? What is the role of MoH/Health Authority/National Program in adapting research findings to local context? Give Examples in relation to the **X Policy.**
IV.B.6	What other factors (other than evidence-base political context for example,) contributed to the formulation of X **Policy**?

V. Responsiveness at the policymaking level

	Responsiveness **KI Interviews Questions;** ***These questions will be asked to key informants through face-to-face in depth interviews***
V.B.1	How do you view MoH/Health Authority/National Program institutional capacity to collect/gather public needs/preferences to be incorporated into policymaking process? What Mechanisms can be used to improve policy responsiveness to the population needs?
V.B.2	What are the factors that can positively or negatively influence the responsiveness of MoH/Health Authorities/National Program to the public needs in the policymaking process?
V.B.3	How does the MoH/Health Authority/National Program balance the competing interests/conflicting needs and influence of professionals/elite groups with public opinion (if there is any conflict present between the two opinions)? And between different groups of elites, or different publics or different social groups?
V.B.4	Does the MoH/Health Authorities/National Program usually respond to media and/or civil societies reports regarding failure to implement policies? How the response is formulated? Please Give Examples
V.B.5	How responsive is the **X Policy** to the population needs in general? And to the vulnerable population needs in particular? Is the policy patient-centered? Please explain
V.B.6	How do you perceive the timeliness as well as the promptness of developing the **X Policy** in response to population legitimate needs?

Exit Interview Questions:

- If you were in High level authority, what would have you done differently?
- Please provide any additional comments if you like

Thank you for your participation in this guidance tool.

Your responses will help to better guide MOHs/Health Authorities/National Program to strengthen governance of the policymaking process that they lead at the national level.

Health Policymaking

Governance Guidance Tool

(HP-GGT)

Manual

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List of Abbreviations

HP-GGT	Health Policymaking Governance Guidance Tool
HSG	Health System Governance
KIs	Key Informants
MoH	Ministry of Health
NGO	Nongovernmental Organization
SWOT	Strengths, Weaknesses, Opportunities, Threats
WHO	World Health Organization

About this Manual:

This manual is intended to serve like a general guide to standardize the process of gathering the evidence for desk review and conduct the interviews as well as how to present and interpret the findings of the assessment.

Chapter I: Introduction to Health Policymaking-Governance Guidance Tool (HP-GGT)

Background

WHO defines governance as "ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, provision of appropriate regulations and incentives, attention to system-design, and accountability" (WHO, 2007B). According to WHO, Governance in health is an essential element for achievement of health millennium development goals (Siddiqi et al., 2009) as well as the post development goals; since Governance is considered one of six building blocks of any health systems (WHO, 2010). Yet, governance is the least understood aspect of these (Siddiqi et al., 2009), most difficult to measure and its implementation the least evaluated (Alliance HPSR, 2008). It was reported that poor governance in health systems contributes to poor performance and poor health outcomes in low and middle income countries (LMG, 2012). This is due to the fact that weak health governance affects negatively utilization of resources and service delivery (Siddiqi et al., 2009). While practicing effective governance can improve health outcomes in those countries (Ciccone et al., 2010). . This can be achieved by overcoming poor accountability and transparency, weak responsiveness, limited engagement of various stakeholders and lack of data and evidence (Siddiqi et al., 2009). To improve governance and subsequently performance of health systems it is believed to be important to identify weak points that contribute to poor governance. Thus, good governance is considered an indicator for performance of any health system (Alliance-HPSR,2008). Similarly, health system reforms are also dependant on good governance in terms of establishing standards, using information and enforcing accountability among others (Lewis et al., 2009).

In addition, international organization reported that weaknesses in health system governance (HSG) can pose a threat to effective use of external funds (USAID,2008) , thus these organizations pose a pressure on governments to improve HSG as way to better manage limited resources and funds in a transparent manner to demonstrate accountability (Alliance-HPSR,2008, Lopez.et.al,2011) .

In an attempt to simplify and clarify what governance is; various organizations proposed lists of principles for what constitute "effective" good governance. Siddiqi et al. proposed 10 core principles that are relevant to the health system governance. These are: strategic vision, participation & consensus orientation, rule of law, transparency, responsiveness, equity and inclusiveness, effectiveness and efficiency, accountability, intelligence & information and ethics (Siddiqi et al., 2009).

To improve something, there is a need to assess it first to identify gaps in practice as well as to identify gaps in knowledge about how to improve it (WHO, 2009). Assessing and understanding governance at all levels of the health system is crucial in order to understand how to improve its performance.

Previously several assessment tools of health system governance have been proposed, but for a range of reasons, they are not widely used (Lopez et al., 2011). Thus, there is a need to develop practical tools that are based on academic rigor.

Rational for Development of HP-GGT:

The rational to develop HP-GGT was based on the importance of assessing HSG as a way of detecting weakness in it that will enable policymakers and researchers to identify possible ways and interventions to improve them accordingly, thus leading to improved health system performance (Kaufman et al., 1999). Another important reason for assessing governance is to raise awareness among public officer, policymakers and others about role of effective governance in the development of health system at all levels by communicating the results of the assessment and to promote common understanding of it and its role and advocate to adopt it and implement it (Siddiqi et al., 2009).

The development of this tool followed a methodological approach to develop a *SMART* governance guidance tool, with aim to have a tool which is capable of analysing health governance in developing countries in a Specific, Measurable, Achievable, Realistic and in a Timely manner.

This work will make a contribution to transform theoretical knowledge on health system governance into more practical application.

Process of Development of HP-GGT:

The development of this tool came as part of the research required to gain a professional doctorate in Health. The research focus was on conducting methodological work to develop a valid and useful tool that is suitable and practical for the assessment of the application and implementation of governance principles at the health policy level. The development of the tool went through 4 different phases.

Phase I: The initial tool was developed based on and building upon existing research to identify key governance principles based on literature review and previous work on health governance, and following academic processes of assessment tools development (Devellis R, 2003). The starting point for the development of this tool is based on a previous work done by

Dr. Sameen Siddiqi "Framework for assessing governance of health system in developing countries: Gateway to good governance" (Siddiqi et al., 2009).

Phase II of the development of tool was to evaluate the developed tool with "Governance Experts" within the health sector to seek informed "expert" opinion on the rigor, content, relevance and conceptual organization of the tool as well as its feasibility and practicality in order to maximize its content validity. The governance experts were consulted using an iterative Delphi-method consultation (which is a flexible group method that does not require panel of experts to meet face-to-face instead through virtual meetings) (Okali C. et al., 2004, Keeny S.el al, 2001). Thus, consultation was done via email and it included 3 rounds of consultations and 25 experts from 16 countries around the world participated in at least one round of consultation (14 experts participated in all 3 rounds). The first round of consultation focused on assessing the comprehensiveness, relevance, and report on any missing aspect as well as providing feedback on wording of questions and the suggested structure of the tool. The first draft of the tool that was sent to experts constituted a long “laundry list” of concepts identified in literature related to selected governance principles. The experts were asked to review at least two sections out of the five sections of the tool. The second round focused on narrowing down the original list to the most important aspects to be assessed. The revised draft of the tool based on Round 1 consultation was sent to experts to revise and validate the revisions implemented from Round 1 responses and to Rate items to be kept in the tool. The final round focused on getting a final feedback on the tool. The third revised version based on Round 2 was sent for final feedback on items retained and to be rated again and ranked, and to give feedback on the practicality and feasibility of the tool. The overall aim of the three rounds of consultations was to generate consensus between experts on final tool to be pilot tested that is a short and practical. Another phase of evaluation was planned before the pilot testing.

Phase III: The methodology and the content of the tool needed to be further refined based on experience and feedback of policymakers. Thus, a consultative one day meeting was planned to be held in presence of high level policymakers from the EMRO region. The specific objectives of the consultative meeting were to finalize the tool to be ready for pilot testing, agree on most user-friendly structure and design and agree on the data presentation of the results of the tool. The consultation meeting was attended by 10 participants from Egypt, Iran, Iraq, Jordan, Lebanon, and Morocco. 2 of the participants were former ministers of health (one of them is a current parliamentary member), 3 general directors at ministry of health/high health council, 2 WHO high level staff, 2 former WHO staff (one of them is currently working in academia) and 1 independent expert. The meeting was funded by WHO.

After the consultation meeting, tool was finalized and was ready for pilot testing.

Phase IV: It was pilot tested in Lebanon and the mental health strategy that was recently developed was used an example for the pilot.

The pilot included face to face interviews with11 KIs who were directly involved in the development of the mental health strategy. The KIs interviewed represented almost all stakeholders who were involved in the formulation phase; 3 from ministry of health, 2 from international organizations, 1 from international NGO, 1 from local NGO, 2 from academia (different institutions), 1 from scientific society, and 1 from a private hospital.

After the pilot, tool was further adjusted and now it is in its final format and ready to be used by developing countries as a way to improve their governance practices at the health policymaking level.

Chapter II: Overview of HP-GGT

Overall Objectives of HP-GGT:

- To identify the main characteristics/aspects of key good governance principles and highlight their significance in health policymaking process
- To have a suitable and practical guidance tool to gather data to identify if these characteristics are evident in health policymaking
- To identify strengths and weakness in practicing good governance principles by Ministries of Health/Health Authorities while developing health policies
- To raise awareness of need to have "Good Practices" of good governance in place to improve the quality of governance practiced by Ministries of Health/Health Authorities

Scope of HP-GAT:

What will be assessed? The HP-GAT is developed in a way to be a valid and practical assessment tool to examine whether **key governance principles** are practiced at the policymaking level. The KEY principles, as identified from existing research, are: participation, transparency, accountability, use of information and responsiveness. Extensive literature review was conducted to reveal various components, major characteristics and relevant concepts of the selected governance principles that are identified to be directly relevant to the health system to gain better understanding of these principles that contribute to the quality of HSG at all levels. The purpose of this step was to go beyond traditional approach of only listing relevant principles of governance by exploring their main characteristics/components for better conceptualization, in other words to unpack these principles. The main characteristics of the principles are readily available in literature but not used comprehensively. Characteristics identified for each governance principle provided a definition of that principle and thus was used as guideline for best practices to be followed to achieve good governance. In this way, concepts will be simplified, understandable and concrete. See Diagram 1: Framework of HP-GGT.

The level of analysis: The selected governance principles will be assessed at the health policymaking process level, where the processes of decision-making at all levels of the health system and the wider influences that underpin the prioritisation of policy issues, the formulation of policies, the processes of implementing policies in practice and their evaluation take place. The tool will be focusing on formulation mainly and to lesser extent on implementation ONLY. For the implementation part, the tool does not cover details of

arrangements of implementation at the local/decentralized levels (i.e service delivery, financing health services, contracting, performance assessment, etc). It mainly will evaluate if implementation arrangements were thought about/planned for well during the policy development.

Thus, the analysis of the governance of health policymaking will take place at the **NATONAL** decision making level. One limitation of the tool is that it will not cover all levels of policymaking process.

The intention for **the HP-GGT to be a generic guidance tool,** as it was designed to be flexible enough to analyse **governance processes** of policymaking of **ANY TYPE** of health policy (from National Health Strategy, Universal Health Coverage, to NCDs, AIDS, Mental Health and any other policy in between). Health policy is all formal written documents, rules, and guidelines that present policymakers' decisions about what actions are deemed legitimate and necessary to strengthen the health system and improve health (Blank et al., 2010, p:2). Thus, this tool can be used to assess any type of health policies that were recently formulated and implemented in a country within the last year. Based on the assessment, recommendations can be made on how to improve the policymaking process in the future. The tool includes questions about the policymaking process in general in relation to good governance, and other questions go into details of policymaking process of the specific policy.

The Unit of analysis: Since, governance is considered a function of MoHs/Health Authorities specifically where they are responsible for promoting and maintaining well-being of population through their role in regulation and policymaking. The HP-GGT is designed to assess abilities of Ministries of Health (MoHs)/Health Authorities (at the central level as well at the peripheral level if applicable as the tool is designed to be flexible enough to be adapted to country context) to practice and adhere to key governance principles at the policymaking process level in developing countries. Thus, the unit of analysis is Ministries of Health/Health Authorities in developing countries. The tool can be used as an entry point by policymakers and/or international organizations to examine the extent to which key governance principles are applied in health policymaking and thus assist Ministries of Health (MOHs)/Health Authorities to better govern their health systems as the tool can be used as a checklist of "Good Practices". The governance tool is developed to be a practical, robust and adaptable for stakeholders to use in diverse developing country health contexts. Thus, this tool serves like a guidance tool and not just as assessment tool.

The Intent of analysis: the focus of the tool is normative/evaluative in nature. The tool will evaluate HOW a policy was formulated not WHAT was formulated. Thus, it will be a

retrospective evaluation of a policy that was developed in the past 12 months. The purpose of guidance tool is to document successes, identify weaknesses, challenges, and recommend ways by which health governance can be strengthened in the future at the policymaking level and thus the recommendations will NOT propose to produce a new policy.

It will be sufficient to conduct assessment at least once (as a learning/diagnostic tool) and not for every type of policy that is being developed.

Who can conduct the tool? It should be conducted as a country demand driven, thus it should be MOHs/Health Authorities led/endorsed. The MOHs/Health authorities can nominate a team from within led by a senior staff to conduct the tool OR nominate someone from academia with a counterpart of a senior staff at the MOHs/Health authorities. Another option is to ask for an external independent body to conduct it.

Structure of the HP-GGT:

The guidance tool is a structured questionnaire and has **TWO separate sections (Section A&B)**; one that contains all evidence-based questions for all the five principles, and another section will contain all the perception-based questions for all the five principles. The relationship between the evidence-based and the perception-based questions is that the latter should help in filling gaps in knowledge and facilitate in-depth interpretation of the data obtained from the evidence based.

Each section is divided into five parts (I-V) and each is concerned with one of the key governance principles: participation, transparency, accountability, use of information and responsiveness. Each principle is assessed separately in relation to how it is applied in policymaking process mainly at formulation level. For each principle, the assessment tool has two sets of question.

The first section is Evidence-based questions that evaluate the existence of certain structures, procedures, guidelines, legislation that indicate the application of the governance principle. Answering these questions is done by face to face interviews with Key Informants (KIs) and asking these KIs to provide documents and evidence to validate their answers.

The KIs will be given 5 options to answer these questions and these are: Yes, No, In Process, I Don’t Know, and Not Applicable or will be asked to choose answers from a list of sub-answers (can choose more than one answer). A content analysis of the relevant documents identified by KIs and through desk-based research will be conducted. Answers in this part of the assessment questionnaire can be used to evaluate progress or changes over time. The long lists of sub-answers to select from are like indicators/examples (and not limited to) of good practices to be

followed/practiced. The questions are developed with the purpose to be practical and operational.

The second section is perception-based that evaluates the perceptions of KIs about practices of good governance. This would be done via face-to-face semi-structured interviews.

Thus, the KIs should be interviewed twice. See Diagram2: See overview of the structure of the tool.

In summary, the HP-GGT is based on current and previous work done by others, it is a generic tool and can be adjusted based on country context, it will cover only one level of analysis; the National policymaking level, it contains a baseline list of questions that will be used to identify key issues; list of "good practices "to reflect if we have good "enough" governance in place. It can be considered an educational/guidance tool as well as a diagnostic tool as negative answers will signal deficiency that need to be addressed.

The HP-GGT is not an end by itself and defiantly not a panacea, it is not a comprehensive toolkit to assess governance of the health system at all levels, it does not cover an exhaustive analysis of the good governance principles, and not all questions are relevant or applicable to different countries.

Chapter III: Methodology of conducting the HP-GGT

Users of the HP-GGT

As it was mentioned earlier, the HP-GGT should be conducted as a country demand driven, thus the MOHs/Health Authorities should initiate or request for the assessment to be conducted in the country.

A team (a minimum of 2 persons) conducting the tool within ministries can be junior staff or from academia who are working under the supervisor of a senior staff at the MoHs/Health Authorities who is experienced and where KIs can cooperate and respond to and have the influence to improve the quality of governance and accordingly can have a key role in carrying out the recommendations of the assessment to higher management levels to decide with relevant stakeholders on the priority areas to be tackled for improvement. In addition, international organizations/donors can conduct the tool in various countries to have a baseline on governance practices, share experiences and advice on what can be done to improve governance quality as well as provide help and support to progress health system governance of these countries.

Steps to conduct the HP-GGT

Before the conduction of the assessment tool, the assessors need to decide on the policy that they want to evaluate its process of development. The policy should be a recently formulated (within the last 12 months) and implementation started in the country.

Then the team of assessors needs to adapt the questions based on the country context and policy type. For example, is the unit of analysis is the MOH or is there an independent health authority at central or district level or is it a national program that is responsible for the formulation for the policy in question.

A mapping of stakeholders is important to be conducted to identify who will be the KIs to be approached for interviews. KIs to be interviewed should include high level officials/senior staff as well as other stakeholders who are knowledgeable about, and were directly involved in the policy formulation of the health policy in question. The selected KIs should be representative of various stakeholders. The KIs number will depend on the number of relevant KIs who were involved and who will accept to participate in the assessment.

Data Collection: Desk Review and KIs interviews

The data collection process has 3 stages:

First, general desk review to compile background material and data collection from various documents should be done and reviewed to have a clear understanding of the specific country context and health system structure in general as the final report of the guidance tool should include an introductory chapter with the following information: **country context**; geographic location and political context, legislative process and local administration, economic profile, demographic profile and health status indicators. Also, it should include the **description of the health sector in general** in terms of health sector overview, reform efforts, levels of decision making, decentralization, policymaking process, health care financing and expenditure on health (national health accounts), health workforce, and service delivery, role of private sector as well as role of NGOs in health. This information can be collected as part of the desk review process. Following the desk review, KIs should be identified to prepare a list of contacts to be approached.

Second, the first set of interviews to be conducted with KIs to collect data related to the evidence based questions using a structured questionnaire and questions will be asked in relation to a specific health policy in terms of formulation and implementation plans.

During this set of interviews, KIs will be asked to provide evidence and documents to validate their answers whenever possible. Also, they will be asked for a SECOND Interview to complete the perception based part of the tool.

Third, the second set of interviews is carried out to collect data for the perception based questions also via face-to-face semi-structured interviews with same KIs (if they agreed to participate in the second interview). The semi-structured interviews will generate in-depth information about the process of policy development.

The reason for having two interviews with the same KIs; is the lengthy questionnaire and to avoid burdening the KIs with a long interview given their limited schedule and fear to loss their interest in the interview. Another reason is to give time to the assessors to read and analyse the documents provided during the first set of interviews. The suggested time between the two interviews is 1 to 2 weeks. Confidentiality and anonymity of the answers will be ensured for all KIs during both interviews and they will be asked to fill an informed consent before the interviews and will be provided with an information sheet. (See Annex 1: B&C).

Questionnaires and notes of the interviews should be kept in secure location and under lock for at least 3 years and then they can be properly destroyed.

Suggested documents to be reviewed:

Ministry publications, administrative and legal records, health laws and policies, statistics, health sector strategy reports, media reports, official web sites, other health system assessments and others. Reports and evaluations carried out by other development/international organizations and partners. NGO reports and websites, Private sector documents and websites, as well as Individuals who are likely to be able to provide insights and access to the documents needed.

Suggested list of KIs to be interviewed:

- MOH leadership (minister, general director) & MoH staff, from all levels of management (senior, middle and junior level) and from various departments
- Staff from other ministries: finance, social affairs, etc..
- Parliamentarians involved in the health sub-committee and others who have interest on health
- Representative of NGOs (local and international)
- Representative of Patient groups relevant to the policy
- Professionals from the private sector
- Representatives of private sector: hospitals, pharmaceutical companies, insurance companies & others
- Representatives of professionals associations, societies and orders
- International organizations working in the country
- Media persons interested in the health sector
- Academia and/or research institutions
- Independent experts/think tanks
- Members of national committees
- Any other relevant stakeholder that is not mentioned above

General Tips for the HP-GGT users:

- Read carefully the questions before data collection and interviews and adjust the questions based on the country context and the policy type to be evaluated.
- Prepare the list of potential stakeholders to be interviewed with contact details (phone numbers and emails)
- Interview as much as possible of KIs till you reach saturation in answers and themes that might emerge

- Approach the potential KIs by contacting them first via email (if appropriate) to request their participation and to brief them about the guidance tool (see Annex 1: A draft letter/email)
- In the email you need to set a deadline for potential KIs to respond to your email, indicate that the interviews are done on two phases and each phase will require one hour. It is up to the KIs to choose to make the two sets of interviews together.
- Send a reminder email to potential KIs who did not respond.
- Take the following with you to the Interview: informed consent (if not signed and sent by email), copy of the questionnaire (both sections), a recorder, a pen, a copy of the policy/strategy in question.
- Ask the KIs about his/her acceptable to be interviewed and tell them why they were chosen to be interviewed.
- Ask the KIs about the available time for the interview and if they would like to conduct both sections together or only one section at a time. If they prefer a second interview, ask them at the end of the interview to set a suitable time for them.
- Introduce yourself at the beginning and the purpose of the tool briefly and highlight the fact that the intent of the tool is not to evaluate the content of the policy but rather to evaluate the process followed to develop the policy, and the tool serve as a guidance tool for the future.
- Ask the KIs for the permission to record the interview during both sections, even the close ended; since there is so much space for elaboration by the KIs
- Highlight that all of the interview will be confidential in terms of identity of the KI and the answers.
- Add a code on the questionnaire and take some notes of key ideas/key words mentioned while the KI answers even if the interview is recorded. Write down exactly what the KI is saying to avoid subjective interpretation if you are not recording.
- Use some probing techniques whenever you feel that the KI did not understand the question or reluctant to answer. Try to ask the question in another way and/or give examples and give some time for the KI to think and answer.
- Ask questions in relation to the KI position/role (academia, NGO, professional).
- Ask KIs to provide you with documents and relevant evidence on what was discussed during the interview.
- Enter the results to the excel sheet immediately after the interviews and start the thematic analysis of the open ended questions.

- Review all notes and complete as needed and write a summary of interview notes including your impression, observations and findings on regular basis and not wait till the end of the interviews are all done.

Displaying Results, Analysis of Findings and Recommendations:

The first part of the data analysis is based on the review of the secondary data compiled as a description of the health system and the policy developed then it should be combined with data collected through interviews and discussions with KIs.

The results of the first section of the tool/first set of interviews (the evidence based questions) can simply be entered using an excel sheet (see annex 2 for a sample excel sheet).

There should be a sheet for each of the five principles: participation, accountability, transparency, use of Information and responsiveness.

The analysis will be a simple statistical analysis; for example how many answered Yes vs. how many answered No for a certain question or sub-question.

The results of this section can be summarized using a traffic light symbol system (used by WHO for pharmaceutical sector profile at country level, WHO, 2014) and NOT a score; as red will be used for NO answers, green will be used for YES answers and yellow will be used for In Process answers. A summary sheet will be prepared for each of the five principles.

III.A.7	**Is there official, up-to-date (within last 5 years), detailed policy document regarding National Health Strategy?**	
	If Yes,	
	Publicly available?	
	Easily accessible?	
	Available on the MoH/Health Authority website?	
	Is it available in the local language?*	

*still under translation

See what traffic light symbol means and an example on how it can be used.

Color Code	Meaning	Applies to
	Does Not Exists/Not Practiced	Main and sub-questions
	In Process Or it Exist but Not applied	Main and sub-questions
	Exist	Main and sub-questions

As for the second section; the open ended questions, a thematic analysis should be conducted by transcribing all the answers of KIs with respect to same questions and then identify common or striking themes that might emerge.

The final analysis of the findings of both sections should be presented in the format of SWOT analysis (Strengths, Weaknesses, Opportunities and Threats) for each of the five principles and then compare and triangulate SWOT and cross-checking findings for all the five principles to come up with common themes. See below a description of SWOT analysis.

Description of SWOT analysis*

* Source: The Health System Assessment Approach: A How-to Manual, Version 2.0, September 2012.

(Principle)	
Strengths	**Weaknesses**
Strengths are elements of the health system that work well, contributing to the achievement of system objectives and thereby to good system performance. Example: Having a national Committee that was issued by a decree assigned the development of Policy X Recommendations should build on the strengths of the system	Weaknesses are attributes of the health system that prevent achievement of system objectives and hinder good system performance. Example: Minutes of Meetings of the National Committee were not documented. Recommendations should suggest how to resolve system weaknesses.
Opportunities	**Threats**
Opportunities are conditions external to the health system that can facilitate the achievement of system objectives. Example: The refugees' crisis in the country was the reason behind initiating work on a new national policy for X. These factors can be leveraged when planning interventions.	Threats are external conditions that can hinder achievement of health system objectives. Example: Resources used to facilitate and enable participation process of all stakeholders are donor based, thus there is no sustainability. Recommendations should suggest how to overcome these threats.

Based on the SWOT analysis, identification of potential recommendations for improvement should be done and thus a list of recommendations should be developed.

After the analysis and the recommendations are finalized, it is suggested that the team of assessors hold a consultation meeting with relevant stakeholders including the KIs and the MOH/Health Authority staff to review and validate the findings and conclusions as well as to prioritize the recommendations with the relevant stakeholders.

Final Assessment Report:

The final assessment report should include the following sections:

- Executive summary: maximum of 2 page summary,
- Introduction: objectives and methodology of the tool,
- Overview of the health system in the country with focus on the policy sector,
- Data presentation/findings of the assessment: summary tables and brief description of total results for each of the five principles in addition to the traffic light symbol summary sheets,

- Data analysis and interpretation: for both sections of the tool; close ended and the open ended,
- SWOT analysis: to highlight the strengths, diagnose weaknesses, and identify key opportunities and threats
- Recommendations: based on the findings, identify potential solutions and recommendations for improvement
- Priority list of recommendations based on the discussion of the consultation meeting
- Conclusions
- References
- Annexes: Including list of evidence obtained

Chapter IV: The HP-GGT: Questions & Explanations of the Questions

Section A of HP-GGT: Evidence-based questions:

This section will include listing of the questions for the 5 principles with Explanation s for each question.

I: PARTICIPATION at policymaking level

Definitions: Everyone should have a voice in decision-making for health, either directly or through legitimate intermediate institutions that represent their interests. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively (Siddiqi S et al. 2009). It is about empowering citizens to have a role in decisions that affect their lives, and reach common goals by participating in policymaking process (Labonte R, 2010). It is the responsibility of the government to create mechanisms and spaces for participation (Cornwall A et al., 2001).

There are many benefits in involving all stakeholders in the policy development process and these benefits are to participants (stakeholders) as well as to policymakers and these include:

- To Participants

Is considered an end by itself, considered a virtue, give a sense of control (self-development process)

Participation as a “Human Right” and reflect a "positive Freedom"

Increase level of policy acceptance by health professionals

Enable citizens to demand accountability, transparency and responsiveness from government institutions.

- To policymakers (governments)

It is a mean to have better/good governance, a mean to enhance other principles/ dimensions of governance, a sign of democracy.

(Charles C et al., 1993, Cornwall A et al., 2001, Gaveta J, 2002)

Many governments, organizations recognize the importance of public engagement in policymaking (Oxman A et al., 2009).

More efficient policy making process due to contribution of knowledgeable actors about policy issue which will result in minimizing errors in policy decisions and actions to be taken and to take into account the different inputs of various stakeholders.

Participation process is also associated with negative impact and these include:

Poorly designed process, time consuming, produce confusing data, conflict of interest, representation issues & legitimacy of representation, informal influence which can affect stakeholders voice inadequate input, hard to reach consensus and manipulative participation.
(Mitton C. et al., 2009; Lopez I. et al., 2011; Gaveta J, 2002)

Questions and Explanations for the questions:

I. A.1 Is there a Legal basis/requirement (Law/Regulation/Policy) to include various stakeholders in the health policymaking process?

Explanation:

Legal framework for participation to be involved in decision making to encourage participation across **all** stages of policy cycle should be in place (Cornwall A et al., 2000).
It is considered a human right; WHO: "people have the right and duty to participate individually and collectively in the planning and implementation of their health care" Alma Ata 1978.
If it is not legally required, there still should be a commitment to ensure some degree of stakeholder participation in formulation and/or implementation (Delphi Expert).
It is important to contextualize a legal basis or framework to support participation in health governance as it opens a space for participation in policymaking processes (Delphi Expert).
Participation in itself is a human right that is commonly neglected by different authorities particularly health authorities. Having a law and regulations which spell out the government commitment is a good evidence for this commitment (Delphi Expert).

I.A.2 Was there a body or mechanism(s) used to involve stakeholders in policymaking process that was concerned with the development of the X Policy? How this body/mechanism formulated? Is there a written scope/mandate? Is roles and responsibilities specified?

Explanation:

There should be a national committee/an advisory board/working group or any other type of body or mechanism to deal with policy development and formulation to facilitate the participation process from all stakeholders. This committee should be officially formed to have an official entity and it can be formed by a law (parliamentary legislation, presidential ordinance, ministerial decree, administrative decision or any other way. This body/mechanism should have a written mandate. Existence of SOPs, by laws, decision rules, conflict resolution mechanisms are a must as it is important to have

awareness/transparency on roles and responsibilities. Need to have shared commitment, motivation, and shared set of values or goals set from the beginning (Cornwall A et al., 2001, Emerson K et al., 2011).

Having this body formally established gives a form of authority (Delphi Expert).

Informal mechanisms to include various stakeholders can be as important given the transparency and accessibility of the process and this need to be looked at (Delphi Expert).

Having a mechanism (formal or informal) is important to ensure a multi-stakeholder perspective and consensus building in the decision making process of policymaking (Delphi Expert).

Roles and responsibilities for each member of the policymaking body should be defined. As long as there are explicit roles, tasks, and responsibilities outlined for participation, each member is therefore accountable and responsible for his/her participation and level of effort (Delphi Expert).

The presence of a body through which participation of different stakeholders are carried out is of utmost importance. However, the regularity of meetings of this body is also very important (Delphi Expert).

I.A.3 Were the various stakeholders represented in the FORMULATION that was concerned with X Policy?

Explanation:

All types of actors in the health sector should be represented at the formulation level to achieve a broad consultation ant to obtain the views of all stakeholders;

- State actors: Politicians, government officials (can be high or middle level officials, policymakers, public health sector agencies: ministry of health, health and social insurance agencies, and public pharmaceutical procurement and distribution entities. Other state actors include: parliamentary health committees, regulatory bodies, ministry of finance, other ministries, various oversight and accountability entities and judicial system.

-**Health Service providers**: mix of public, private and voluntary sector providers working in: hospitals, clinics, laboratories, and educational institutions, insurance companies, health maintenance organizations, pharmaceutical industry, equipment manufacturers and suppliers

-**Beneficiaries**, users, recipient: patient, guardians of patients, lay people, service users, interest groups, advocacy groups, policy audience, citizens, tax payers, non-governmental organizations, civil society, poor and marginalized groups, Consumer associations, Patients associations, Commercial stakeholders (whose interest may be affected by set policies).

(Labonte R, 2010, Smith K et al., 2013, Brinkerhoff D et al., 2008, Oxman A et al., 2009).

- **Most vulnerable groups** should also be included in the policymaking process including women

- **Others:** journalists (media, academia, researchers, think tanks, champions, donor (Mutale W et al., 2013, Bennett S et al. 2012).

There is a need to have a balance between public vs. private and public representation and professionals and other participants to avoid dominance by one group over the other and information imbalance

I.A.4 For each category of stakeholders identified above, how were the participants involved in formulation of X Policy selected?

Explanation:

Participants can be appointed/nominated, elected, self-selected or selected by any other mean but for all of these and for transparency issues there is a need to have set inclusion and diversity criteria. It is also important to clarify where the participation of the various stakeholders is done on voluntary basis or mandatory since this will reflect on accountability of these participants (Brugha R et al. 2000, Charles C et al., 1993, Emerson K et al., 2011).

Also participants can represent:

- Themselves
- Client
- Public Agency
- NGO
- Community
- Private sector

(Emerson K et al., 2011).

This should be identified and declared to others to avoid any conflict of interest.

Ensuring a good mix of stakeholders representing industry groups and non-state actors such as NGOs and academia will enhance the discussions during the policy formulation. The NGOs provide for the pragmatic and implementation approach, while academia can provide for the policy framework and evidence-base and private industry groups can provide for the markets' experience. These are essential perspectives that help government shape their policies (Delphi Expert).

I.A.5 Is there a gender balance /consideration (Male vs. Female) among the stakeholders participating in the formulation of the X Policy?

Explanation:

It is important to highlight the importance of women participation in the policymaking process.

It would be interesting to know if there is a balance between male vs. females (Delphi Expert).

It is important to have gender balance in participation for fair representation issues (Delphi Expert).

In some countries females are highly discriminated and their voices are not being heard, while in others this is not the case. So, identifying whether this is the case with regard to policy formulation in a certain country reflects in stakeholder participation (Delphi Expert).

I.A.6 Are there dedicated resources made available by the MoH/Health Authority to enable and facilitate participation during the policy development process of X Policy?

Explanation:

Resources need to be available to facilitate and pay for costs of meetings (venues, coffee breaks and other meals) and administrative work (print outs, etc) related to meetings (Smith K et al., 2013, Matthews A et al. 2008).

Also, it is recommended to provide incentives for participation in the form of fee or honoraria or at least provide reimbursement for transportation and lodging as a way to encourage participation and commitment (Emerson K et al., 2011).

Lack of participation could be due to lack of dedicated resources, thus there is a need for dedicated resources to cover for cost of meetings, travelling, etc. (Delphi Expert).

I.A.7 Is there documentation (Minutes of meetings) on the recommendations submitted for final decisions in relation to the formulation of the X Policy?

Explanation:

Participation process should be recognized by documentation and minutes of meetings need to be made public for transparency (Charles C et al., 1993, Oxman A et al., 2009).

Documentation of the process is very important and should be stressed. It is evidence and is important for learning and lessons to be discerned (Delphi Expert).

I.A.8 How final decisions were taken by participants?

Explanation:

Final decisions can be reached by Majority vote, consensus, and dissenting opinions or by any other procedure. In order to have ‘effective participation” there is a need to reach consensus; as stakeholders and citizens positions/voices should be taken into account not

just allow free expression of opinions and not by majority or by elite (Cornwall A et al., 2001, Emerson K et al., 2011, Gaveta J, 2002).

Documentation of how decisions were made is crucial; for transparency and accountability issues to minimize as much as possible the power struggle and competition between different stakeholders (Lopez I et al., 2011).

I.A.9 Are the roles and responsibilities of the various stakeholders in the implementation process specified in the formulation document of the X Policy?

Explanation:

For transparency as well as for accountability issues, it is very important to specify the roles and the responsibilities of the various stakeholders in the implementation phase. Having these specified in the policy document will reflect a well-planned (thought of) implementation phase.

It is important to clearly define the roles and the responsibilities of various stakeholders in the policy implementation. Especially if non-state stakeholders will be receiving grants or monetary compensation by the state for implementing such policy and this should be clearly stated in the policy document. Then there should be a clear mechanism for accountability of roles as well as public funds (i.e open call through competitive bidding, signing of contracts, and reimbursement of implemented activities) (Delphi Expert).

Implementation phase need to be thought of very clearly and deeply, otherwise the strategy might not be translated properly (Delphi Expert).

I.A.10 Is there a participatory body to oversee the implementation of the X Policy?

Explanation:

Participation should continue through all the policymaking cycle and phases and thus continuing the participation is essential to ensure ownership and success of the policy implementation (Emerson K et al., 2011).

Oversight role of stakeholders' in implementing policies and strategies is very crucial to the process (Delphi Expert).

I.A.11 Are other mechanism/strategies used by MOH/Health Authority/National Program to ENCOURAGE participation (express opinions/preference and encourage feedback) of different stakeholders in priority setting and in policymaking process of X Policy?

Explanation:

It is the responsibility of the government to create and facilitate mechanisms, spaces and places to encourage **citizen participation** of all who are interested. Engaging the public requires planning and resources from the government (Bishop B et al. 2009).

Different Methods/mechanism/strategies can be used to encourage participation of citizens and these include: opinion poll**,** need/ impact assessments, attitude surveys, focus groups, public hearings, citizens' juries, roundtables, voting, inter-governmental conferences, policy dialogues, third-party facilitated conflict resolution and committees and online platforms for the public engagement is also recommended (Papadopoilos Y et al. 2007, Charles C et al., 1993, Mitton C et al., 2009, Oxman A et al., 2009).

II. ACCOUNTABILITY at policymaking Level

Definitions: Is about assuring that those who are responsible for designing and implementing policies are held accountable for their performance (Dieleman M et al. 2011). Decision-makers in government, the private sector and civil society organizations involved in health are accountable to the public, as well as to institutional stakeholders. "This accountability differs depending on the organization and whether the decision is internal or external to an organization" (Siddiqi S et al. 2009). "It is about having the right checks and balances put into place" (Dieleman M et al. 2011). It is ensuring that all health system actors are held publicly accountable (WHO, 2007a, ch:6).

To assess accountability, it is important to assess whether formal accountability mechanisms are in place, the effectiveness of these mechanisms, and evidence that these mechanism are being used (Delphi Expert).

Questions and Explanations for the questions:

II.A.1 Does the MoH/Health Authority/National Program require signature of contract/Memorandum of understanding/Terms of Reference (that include incentives, sanctions, timeline, deliverables, etc) with various stakeholders before engaging them in policy formulation and implementation.

Explanation:

Various stakeholders should be informed before being engaged in policy formulation and implementation about what their roles and responsibilities will be; this is to ensure accountability of all (Delphi Expert).

II.A.2 Are the different stakeholders (public officials & non-state actors) involved in the policy formulation related to X Policy formally held accountable based on their contribution for decisions and policies borne out in case of false advice/failure to engage in appropriate action?

Explanation:

Usually accountability focus on public health sector, but it should include accountability of private sector, donors, NGOs, and citizens.

Decision-makers in government, the private sector and civil society organizations and other stakeholders involved in health policy formulation should be held accountable to the public, as well as their institutions (WHO, 2007a, ch:6).

Accountability of participants is important; they should be held accountable for their position while participating and for not actively involved (Delphi Expert).

Each stakeholder should be accountable to their institutions (Delphi Expert).

Governance is a shared responsibility and not only the responsibility of the government (Delphi Expert).

II.A.3 What is the type of the accountability mechanisms/types used by MoH/Health Authority/National Program and various institutions/organizations involved in policy towards their representatives?

Explanation:

There are various types of accountability mechanisms and these include: Ethical, Professional and/or performance, legal, financial and other types (Saltman R, 1997, Emanuel E et al., 1996).

This question highlights the fact that various accountability measures and safeguards can be used and not only the legal one (Delphi Expert).

II.A.4 Does the MoH/Health Authority/National Program conduct any of accountability evaluation as part of holding its staff accountable for their role in implementing the X Policy?

Explanation:

Internal accountability is as important as external accountability. Internal accountability is about having the" right checks and balances" put into place. It is ensuring that all components of the system are held publicly accountable (Murthy R, 2008, Ebrahim A, 2003).

Internal accountability can be conducted in the form of evaluation of performance of individual staff and it is usually done on annual basis, administrative/performance audit of the relevant department also done on annual basis, financial auditing for personnel, operations, supplies and others, and contract oversight (Delphi Expert).

There should be in place institutional mechanism for accountability (Delphi Expert).

II.A.5 Are any of the following tools used by MoH/Health Authority to foster accountability?

Explanation:

Many tools can be used to enable accountability and these include: information System in place, Dissemination of information, Participation of Public/Civil organizations, Whistle blowing mechanisms, Watchdog organizations, and Performance incentives for good performance, Enforcement of rules & regulations, appeal mechanisms (Taryn V, 2008, Brinkerhoff D et al., 2008, Ebrahim A, 2003).

Mechanisms to generate and share publicly information are essentials although Information system is important but might be costly. Clear responsibilities of all participants are important to ensure accountability (Tuohy C, 2003).

II.A.6 Is there monitoring & evaluation (M&E) of implementation of X Policy?

Explanation:

Monitoring and Evaluation are important to measure/assess level of adherence to or compliance (Emanuel E et al., 1996) by professionals/private sector with the criteria for specific policy issue as well as monitoring and evaluation policy outcomes in terms of health improvement, efficacy, equity and quality.

Monitoring and evaluation is a tool for oversight (Delphi Expert).

It is important to have M&E as a follow through on the policies in effect to see if they are relevant, effective and efficient or whether these policies are implemented due to compliance only (Delphi Expert).

II.A.7 If Question II.A.6 is YES, Is the M&E process formal?

Explanation:

It is advised to have a formal process of M&E and it can be conducted by independent body (can be either internal within the health sector or external) or it can be done as a self-responsibility. The M&E should be done on regular basis at least once per year.

It is important to know if the process of M&E follows a structured format (Delphi Expert).

II.A.8 Did the MoH/Health Authority/National Program set a formal mechanism (s) to hold implementers and/or implementing bodies from the private sector/non-state actors responsible for implementation of various components of X Policy accountable in-line with set timelines and targets?

Explanation:

To have meaningful accountability, you need to have the following components: setting standards, Investigation and Answerability including allowing justifications, Sanctions, Enforcement mechanisms as well as Rewards for Performance and an independent appeal mechanism (Brinkerhoff D, 2004, Murthy R, 2008).

The presence of all the components together is essential to have accountability. Answerability can reveal "illegal or inappropriate actions and behaviors" that should be followed by sanctions (Brinkerhoff D, 2004). On the other hand, enforcement is about ensuring compliance with sanction decisions (Murthy R, 2008).

Accountability is not only about having sanctions it is as much about giving incentives and rewards (WHO, 2007a, ch:6).

This question will give an indicator whether accountability mechanism is established and operates in accordance with good governance (Delphi Expert).

II.A.9 If Question II.A.8 is Yes, Who is authority responsible for holding implementers and/or implementing body accountable?

Explanation:

It can be internal within the health sector, external by independent bodies or external by the public. It can be the MoH/Health authority itself or an audit office. "Accountability differs depending on the organization and whether the decision is internal or external to an organization" (Siddiqi et al., 2009).

It is about having the "right checks and balances put into place" (Dieleman M et al., 2011). It is ensuring that all health system actors are held publicly accountable (WHO, 2007a, ch:6).

It is important to identify who is responsible for accountability mechanisms and if formally recognized and has a mandate and authority to perform its role and impose sanctions according to predefined rules (Delphi Expert).

II.A.10 What are the types of sanctions applied/might be applied to implementers and/or implementing bodies responsible for implementation of X Policy in case of violation/not adhering to standards set? Failure to implement?

Explanation:

Sanctions: include Legal sanctions through judicial system, Regulatory/administrative sanctions:(like licensing and accreditation standards, quality assurance guidelines and compliance mechanisms, code of conduct, etc) and/or Softer sanctions include: negative publicity (name and shame) (Brinkerhoff D, 2004, Murthy R, 2008).

II.A.11 Are there any laws in place related to the X Policy? What does the law(s) cover?

Explanation:

Rule of law is another dimension of governance and it is related to accountability as well. "It is about having legal frameworks pertaining in health that should be fair and enforced impartially, particularly the laws on human rights related to health" (Siddiqi S. et al., 2009).

"Enforcement of health-related legislations is important as it shows the extent to which various health-related laws are applied at all levels of health system (and government)" (Kirigia J et al., 2011).

III. TRANSPARENCY at the Policymaking Level

Definitions: It is actively disclosing information on how decisions are made (Taryn V, 2008, implemented and evaluated. It is built on the free flow of information for all health matters. Processes, institutions, and information should be "directly accessible to those concerned with them, and enough information is provided to understand and monitor health" (Siddiqi S et al. 2009).

Transparency is about ensuring that all relevant information and processes are documented and are publicly available and easily accessible. Most of the time a lot of information is available, but the MoH/Health Authorities need to have the right balance as information overload is confusing while essential information is not easy to find (Delphi Expert).

Questions and Explanations for the questions:

III.A.1 Is there a law/mechanism about "access to information" that allow access by the general public to government information and documents?

Explanation:

There should be Existence of access to information law as a method to increase transparency (Oxman A et al., 2009).

III.A.2 Is there a law/government policy in place to promote "cyber transparency" electronic government services to improve public access to government information and services?

Explanation:

Having a law to enforce the use of electronic government services will increase transparency and improve public access to government information and services (Oxman A et al., 2009).

III.A.3 Is there an official website for the MoH/Health Authority?

Explanation:

Using E-Government is another method for increasing transparency (Oxman A et al., 2009).

The downside of E-transparency is information overload and not finding easily the information needed. Thus, user-friendly and easy access should go hand in hand with transparency (Delphi Expert).

III.A.4 Are decisions related to priority setting in relation to the X Policy made public?

Explanation:

Availability of such decisions is a sign of transparency (Otenyo D et al., 2004)

III.A.5 Are decisions related to resource allocation in relation to the X Policy made public?

Explanation:

Availability of such decisions is a sign of transparency (Relly J et al., 2009).

III.A.6 Is there official, up-to-date (within last 5 years, detailed policy document regarding X Policy?

Explanation:

It is not enough to make information available, it is the speed of making the information available is the critical aspect of transparency. Documentation of all policy stages should be done by policymakers, and the policy document should be updated every 5 years.

To have full transparency, need to make all policy documents publicly available and enable ease of access to all information (example to place it on the website) and make the available information in an understandable language to the public (make documents available in national language of the country) (NAO, 2012, Otenyo D et al., 2004, Taryn V, 2008).

Publicly available and easily accessible are signs of transparency (Delphi Expert).

III.A.7 Does the document related to X Policy include various types of information?

Explanation:

Content of the information is another important criteria for transparency. policy document should include: background on how the policy was formulated, evidence used in policy formulation, stakeholders who participated in policy formulation, other factors that influenced the policy formulation, responsible body for releasing the policy, budget and funding requirements, timeframe for implementation, indicators and targets, M&E plans and intended audience for the document.

As availability of all of these information in the policy document is a sign of transparency (Delphi Expert).

III.A.8 Is there plans to publish/already publish documents that are related to implementation of X Policy?

Explanation:

As a sign of transparency, the MoH/Health Authority should publish information related to implementation and these might include: Five year strategic plan/operational plan/Implementation plans, Program documents, relevant official decisions to guide implementation, policy evaluation repots, financial reports, contracts made for implementation (if applicable), scientific publications and others.

It is important for transparency to demonstrate the intent and/or progress made in policy implementation (Delphi Expert).

III.A.9 Does the MoH/Health Authorities/National Program release information related to formulated and implemented X policy in "predictable manner"/Periodic/regular manner?

Explanation: Predictability is one factor to be included in transparency. It means that the relevant stakeholders and the public can expect when to receive information in a predictable manner. This means that there should be published timelines which include what to expect (Delphi Expert).

III.A.10 Did participants declared any conflict of interest by signing an official form?

Explanation:

Participants declaring their affiliation and any relationship and/or remuneration that might influence their participation and contribution to the policy development and implementation is a sign of transparency and this declaration does not mean that they do not have the right to provide their feedback (Delphi Expert).

Most stakeholders will have conflict of interest; it is inherent to them being actors in the health system. If only neutral parties are consulted, then we miss capturing stakeholders' real positions. It is just a matter of declaring these conflicts to everyone around the table (Delphi Expert).

III.A.11 Which of the following methods, if any, the MoH/Health Authority/National Program is using or has used in the past 12 months, to INFORM/Disseminate to stakeholders (including the public) about policy formulation, development, implementation and progress of X Policy?

Explanation:

It is the "right of the public to seek, receive and impart information" (Gostin et al., 2003).

It is the responsibility of the government to inform all the stakeholders as well as the public on developments of policies and their implementations and this should be done using various channels like mass media (TVs, radios, wide advertisement (newspapers, billboards, bulletins/newsletters, emails, social media, smart phone applications and any other appropriate mean (Oxman A et al., 2009).

It is important for the MoH/Health Authority to disseminate information about new policies once they are finalized and adopted as a sign of transparency (Delphi Expert).

How decisions are made public is important to participation, transparency and accountability (Delphi Expert).

Dissemination of health policies to the general public (who are the direct beneficiaries in Health) should be done on regular basis (Delphi Expert).

IV. USE OF INFORMATION at the policymaking Level

Definitions: "Is essential for a good understanding of health system without which it is not possible to provide evidence for informed decisions that influences the behavior of different interest groups that support, or at least do not conflict with, the strategic vision for health. It includes; information generation, collection, analysis and dissemination" (Siddiqi S et al. 2009). Sound and reliable information is essential for health system (WHO, 2007a, ch:3).

Questions and Explanation s/Explanations for the questions:

IV.A.1 Is the MoH/Health Authority/National Program directly involved in information generation, dissemination, and publications in relation to policymaking?

Explanation:

The MOH/|Health authority should have a role in generation of information as well as in use of information in policy making (Siddiqi S et al., 2009, WHO, 2007a, ch:3).

IV.A.2 Is the MoH/Health Authority/National Program using data collection tools, data management technologies, validation of data sources, checking sources of funding of research to be used in policy?

Explanation:

MOH/Health Authority should ensure the use of appropriate tools to have proper information generation/production, collection, & analysis of information needed to decision making (WHO, 2007a, ch:3).

It is important for MoH/Health Authority to have a mechanism in place to double check if research used is financed by private or any other entity that has conflict of interest in relation to the policy in question (Delphi Expert).

IV.A.3 Does the MoH/Health Authority/National Program have any form of partnership/collaboration with research centers inside as well as outside the country?

Explanation:

Collaborating with academia and or research institutions is an important way to promote information/research uptake into policies (Oxman A et al., 2009). Also allocating funds on yearly budget for research related to policy can promote information/research uptake into policies and encourage knowledge driven approach (WHO, 2007a, ch:6).

Regular interaction between researches and policymakers will increase the possibility of using evidence in the policymaking (Delphi Expert).

IV.A.4 Does MoH/Health Authorities make Raw data generated at health facilities/health service delivery level accessible to researchers?

Explanation:

Part of governance is sharing the information that is needed to inform policies and to conduct relevant research. Data generated at the health facilities level should be easily accessible by researchers (Delphi Expert).

IV.A.5 Is there a specialized unit/staff in the MoH/Health Authority/National Program that deals with research analysis for policymaking?

Explanation:

MOH/health Authority needs to have institutional capacity for research analysis for policy formulation (WHO, 2007a, ch:3).

For better generation, use and analysis of information, institutional capacity as well as resources and regulatory support are required (Delphi Expert).

IV.A.6 Was the developed X Policy informed by scientific evidence?

Explanation:

Research findings are needed to support arguments, justify choice of policies, and inform decisions. Scientific evidence use in policy formulation can help in finding solutions that are effectiveness and cost-effectiveness (Policy Innovation for Health, Ch:2, Lavis J et al., 2004).

IV.A.7 If Questions IV.A.6 is YES, Which of the following criteria were used for the inclusion of scientific evidence in policy formulation of the X Policy?

Explanation:

Evidence based used in policy formulation need to be reliable and of good quality, up-to-date, extensive and comprehensive enough, and locally appropriate (WHO, 2007a, ch:3).

Evidence used can be international, national or based on community level (Lavis J, 2006).

IV.A.8 Were other types of information utilized in the policy formulation of X Policy?

Explanation:

Other types of information like expert opinion, financial information, governing laws, political direction, and others can be used in policy formulation in addition to scientific evidence. They can be used on regular basis and in emergencies at all levels of policymaking process and should be available to all interested stakeholders (WHO, 2007a, ch:3).

IV.A.9 Does the MoH/Health Authority/National Program publish/plan to publish periodic progress reports/M&E reports on policy implementation status of X Policy?

Explanation:

MoH/Health Authority should publish regularly progress reports on implementation of policy as well as reports of M&E. This is as part of its role in generating information and

promoting transparency. Such reports should be disseminated widely and all stakeholders should have access to such information to encourage transparency, accountability and responsiveness.

It is important to disseminate relevant information to M&E results. It is a sign of transparency as well (Delphi Expert).

It is very important to disseminate such information as it will ensure the right accountability through ensuring visibility and transparency (Delphi Expert).

IV.A.10 If Questions IV.A.10 is YES, What are the objectives of progress reports?

Explanation:

The objectives of the progress reports should be clearly stated at the beginning of the report. The purpose of producing and generating progress reports on implementation should include all of the following: increase awareness, evaluate the situation, identify problems, provide information and assign responsibilities (Cornwall A et al., 2000).

V. RESPONSIVENESS TO POPULATION NEEDS at the policy making level

Definitions: "Institutions and processes should try to serve all stakeholders to ensure that the **policies** and programs are responsive to the health and non-health needs of its users" (Siddiqi et al., 2009). Responsiveness is how well the health system meets the legitimate expectations of the population for non-health enhancing aspects/dimensions of their interaction with the health system (Darby et al., 2000).

Also, according to WHO, responsiveness is important for many reasons:

- "Addressing the legitimate expectations of people is at the heart of the stewardship function of health systems"
- Responsiveness is "fundamental because it relates to basic human rights".
- A health system can "improve some of the elements of responsiveness without large investments" as it does not necessarily require new legislations to authorize it.
- "Responsiveness can be improved much faster than health" (Darby C et al., 2000, Gostin L et al., 2003).

The interactions of people with a responsive health system will improve their well-being, irrespective of improvements to their health (Gostin L et al., 2003). By ensuring that people are treated in ways that correspond to their needs; they will be empowered to lead healthier lives (Gostin L et al., 2003).

Responsiveness is classified as a principle of good governance and is also considered as a DIRECT outcome of good governance. Unlike other outcomes (like equity, efficiency and

effectiveness) that might be the results of other factors all working together in addition to good governance.

WHO defined 8 domains for health responsiveness as well as a strategy for measuring it. Health responsiveness was tackled at the service delivery level only. The 8 domains include: respect for the dignity of persons, confidentiality, autonomy to participate in health related decisions, prompt attention, access to social support networks, basic amenities of adequate quality of care, choice of health care provider and communication (Darby C et al., 2000, Gostin L et al., 2003).

Questions and Explanation s/Explanations for the questions:

V.A.1 Does the X Policy include an objective/goal that MoH/Health Authority/National Program will ensure access to adequate Quality of care services to ALL the population/patients including disadvantaged/vulnerable groups to be covered by the policy?

Explanation:

The MOH/Health Authority should ensure that the population will have access to adequate quality of health care services. As this is one of the domains of responsiveness (Gostin L et al., 2003).

V.A.2 Does the X Policy include an objective/goal that the health services will respect the confidentiality and the dignity of the population/patients?

Explanation:

Confidentiality and respect for the dignity of patients are two of the domains of responsiveness (Gostin L et al., 2003).

There should be guidelines and standards at the health facility level to respect confidentiality and the dignity of patients (Delphi Expert).

V.A.3 Does the X Policy include an objective/goal that the health providers will respect the rights of the patients in terms of autonomy to participate in health related decisions, freedom of choice of health care provider, provide all information related to the patients' medical conditions in an understandable manner.

Explanation:

Autonomy to participate in health related decisions, choice of health care provider and right to get all information related to patients' medical condition are domains of responsiveness (Gostin L et al., 2003).

V.A.4 Does the X Policy refer to the explicit benefit package to be provided to patients at the different levels of care?

Explanation:

It is the right of the patient to know his rights and responsibilities and these should be clearly stated and this will reflect how the health system is responsive (Delphi Expert).

V.A.5 Does the X Policy include an objective/goal that the health services will be provided to population/patients within reasonable timeframe?

Explanation:

Providing prompt attention to the patients is another domain of responsiveness (Gostin L et al., 2003).

V.A.6 Does the X Policy refer to how referral of patients will take place from one level of care to the other?

Explanation:

Patients should know what to expect in terms of referring their medical cases from one level to another and how this referral will take place with stating time frame for this referral and these should be clearly stated and this is a again a sign of a responsive health system (Delphi Expert).

V.A.7 Does the X Policy include an objective/goal to set in place an official complaint mechanism?

Explanation:

Part of being responsive to the needs of people is to have a complaint mechanism in place to allow the public to report any violation or raise concerns about services provided to them (Delphi Expert).

In order to encourage people to use such mechanisms it is crucial to ensure follow up on complains reported.

The investigation on complains should be done in a timely manner and the results should be published (actions and justifications) (Delphi Expert).

V.A.8 Was a needs assessment (targeting the public)/Public Opinion surveys conducted as part of the X Policy formulation process?

Explanation:

Assessing responsiveness of the health system should be based on consumers/users feedback as they are the best source of information. As it is important for policymakers to understand the perception of people about responsiveness of the health system to their needs and assess factors that contribute to this perception as well as understand the preferences of people about the health system and allow them to express their needs to address them appropriately (Darby C et al). Most of the time this is not the case, as

population health needs are usually determined by the health professionals with little involvement of the public (Siddiqi S et al., 2012). Thus, it is crucial to have needs assessment targeting the public during the policy formulation process (Siddiqi S et al., 2009). It could take the form of surveys, public forums, telephone hotline or any other appropriate mean (Delphi Expert).

V.A.9 Do the monitoring & evaluation plans of the X Policy include a component to assess whether the policy is meeting the population needs through conducting patients satisfaction surveys/exit surveys?

Explanation:

It is important to be able to assess the various elements of responsiveness as part of the specific policy under evaluation. This will give a valuable input on the policy for improvement if needed.

It is a governance issue to see if the policy in question is meeting the people's expectations and thus it is important to be included in the evaluation phase (Delphi Expert).

V.A.10 Did the MoH/Health Authority/National Program develop a communication strategy to inform the public about the X Policy?

Explanation:

Communication is another element of responsiveness (Darby C et al., 2000).

The communication strategy is needed to ensure that information is freely available and directly accessible to the public. It also should ensure that enough information is provided and that it is provided in easily understandable forms and media (Delphi Expert).

Section B of HP-GGT: Perception-Based Questions

I. Participation at the policymaking level

Questions and Explanation s/Explanations for the questions:

I.B.1 How do you view the role of MoH/Health Authorities/National Program in encouraging stakeholders' participation in policy formulation and implementation in general? & in the X Policy development in specific? Does the MoH/Health Authority/National Program has the institutional capacity and needed resources to facilitate the participation process? In terms of leadership? Planning? Needed information? Institutional arrangements? Database of key stakeholders?

Explanation:

MoH/Health Authority should encourage participation and creating appropriate spaces for that.

To have a successful participation process, the MoH/Health Authority should have the needed resources and skills to bring partners together; thus need technical & institutional capacity (Emerson K et al., 2011).

I.B.2 To what extent was the formulation process of the X Policy inclusive of the key stakeholders? Were they "Effectively "consulted in? Were all relevant voices taken into account? Which stakeholders were missing?

Explanation:

All stakeholders should be represented at the formulation phase. State actors are usually are responsible for formulating health policies. Health service providers can have a role at the formulation phase with technical input (Brinkerhoff D et al., 2008). Beneficiaries can be involved at the end of the policy development phase (determining details of implementation rather than broad policy formulation) (Charles C et al., 1993).

To have effective and fruitful participation process; there should be:

consensus orientation, informed participation, existence of written documents about SOPs, by laws, decision rules, conflict resolution mechanisms, awareness/transparency on roles and responsibilities, shared commitment, motivation, and shard set of values or goals (Cornwall A et al., 2001, Emerson K et al., 2011).

I.B.3 What type of process was applied for the selection/identification of participants in the X Policy formulation? Do you consider that it was a fair/effective process to ensure a qualified group? A representative group? Why?

Explanation:

The process of selection/identification should be transparent and influence free (Papadopoulos Y et al., 2007).

The process of selection should be fair, transparent and effective (Delphi Expert).

I.B.4 Who were the powerful stakeholders in the decision making/formulation of the X Policy? Was their influence hindering or facilitating the formulation process of X Policy? What their influence led to?

Explanation:

There will always be powerful stakeholders and it is important to identify them and know their influence (Lopez I et al., 2011). There will always be a complex interaction between various stakeholders with different objectives, power levels & how policy decisions may affect them and these need to be identified given the context of the policymaking process.

This question will give an insight about the power matrix and how this can be mitigated (Delphi Expert).

I.B.5 What are the barriers and/or facilitators to the participatory process? For MoH/Health Authorities/National program? For stakeholders?

Explanation:

There are many facilitators as well as barriers to the participation process to take place, some are listed below:

- Political will & commitment
- Level of interest of policymakers & stakeholders
- Power struggle & competition between stakeholders
- Values and ethics
- Evidence, access to information
- Availability of resources
- Trust in policymaking process
- Supportive environment & context
- Public satisfaction in implementation

-Legal framework for participation in decision making

-Generate capacity to participate: including; procedures & institutional arrangements, leadership, information, and resources

- Incentives & contracts

(Smith K, 2013, Matthews A et al. 2008).

I.B.6 What are the mechanisms used to enable stakeholder participation in policymaking process? Do they include mechanisms to give voice to the traditionally voiceless groups (homeless, migrants/refugees, unemployed, minorities, disabled, elderly, etc?? How do you view the effectiveness of these mechanisms?

Explanation:

There should be mechanisms in place to give a chance for vulnerable groups to participate in decision making related to their health or at least be consulted and heard (Delphi Expert).

MoH/Health Authorities should make some kind of investments to help enable and facilitate the participation of most vulnerable as they may not have formal education or skills to amplify their voice (Delphi Expert).

II. Accountability at the policymaking level

Questions and Explanation s/Explanations for the questions:

II.B.1 To what extent do you agree that all stakeholders should be held accountable for their role in the policymaking process including formulation?

What is the best way to hold the various stakeholders accountable for their role in policymaking? How to ensure that they know they will be held accountable prior to their involvement?

Explanation:

All stakeholders should be held accountable; public health sector, private sector, donors, NGOs, and citizens if they are taking a part in the health policy making process. Various stakeholders should be held accountable by their institutions and by the public (WHO, 2007a, ch:6).

Holding everyone accountable in an equal manner is a sign of good governance. This will result in control the misuse and abuse of public resources and/or authority (Taryn V, 2008).

II.B.2 What is the role of media in accountability in policymaking in your setting? Is media playing a positive or negative role in Policy making process? Give examples

Explanation:

Media has an important role in holding the various stakeholders accountable. Media can play a positive role as well as a negative role and thus media needs to be well informed.

Some countries cite media as a good ally for accountability "shame and sensationalism", so it will be good to see how effective the role of media as an accountability mechanism is perceived (Delphi Expert).

II.B.3 Does the civil society have an active role as watchdogs over policy formulation and implementation of Policy X? How? Give examples

Explanation:

Civil societies can have an active role as watchdogs' organizations (Taryn V, 2008).

It is important to get insights on how influential the civil society organizations voice in the country (Delphi Expert).

II.B.4 How the public can hold various stakeholders accountable for their role in policymaking in general and in relation to Policy X?

Explanation:

There is a need to establish mechanisms for citizen oversight (Brinkerhoff D et al., 2008) through health boards or other mechanisms to enable civil organizations to demand explanations for certain health issues or decisions.

II.B.5 How the implementing bodies are held accountable for their roles in the policy implementation process of X Policy? Are all held accountable in equal manner? Give examples

Explanation:

There should be a body responsible for holding all implementing bodies accountable for their role in implementing the policy whether it is the MoH/Health authority or an independent body (Murthy R, 2008, Ebrahim A, 2003).

Holding all implementing bodies accountable in an equal manner is a sign of good governance. This will provide assurance that resources are used and authority is exercised according to legal procedures, professional standards, and social values (Taryn V, 2008).

II.B.6 How is the law (s) related to X Policy translated into rules, regulations and procedures? Who is responsible for this? How does the MoH/Health Authority/National Program ensure that regulations, legislations and sanctions are fairly enforced in relation to the implementation of the X Policy in both public and private sector?

Explanation:

There is a need to establish clear procedural rules and use authority to enforce those roles (Brinkerhoff D et al., 2008).

Enforcement is ensuring compliance with policies and sanction decisions (Murthy R, 2008).

III. Transparency at the Policymaking level

Questions and Explanation s/Explanations for the questions:

III.B.1 Does the MoH/Health authority /National Program have the interest/ willingness/ Commitment to achieve better transparency? What is the type of this willingness/ commitment? How can the MoH/ Health Authority/National Program increase its transparency in the policymaking process? Does the MoH/Health Authority/National Program have the needed capacity/means to achieve better transparency?

Explanation:

The MoH/Health Authority can increase its transparency in various ways, among which is existence of access to information law, availability of publications (public service reports, government documents or decisions, Public databases, Public meetings, Financial monitoring reports, etc., availability of written standards on operating procedures, decision making process, minutes of meetings, availability of written criteria for choosing participants & terms of reference, practice of E-Government: existence of official website, online services, having a freedom of press, and dissemination through media and finally having communication strategies with media and reports published in media (NAO, 2012, Oxman A et al., 2009).

III.B.2 How the MoH/Health Authorities/National Program can ensure that the opinions of the different stakeholders are documented & disclosed/published as part of a transparent policymaking process?

Explanation:

Transparency of the participation process is important; stakeholders' positions should be transparent to be held accountable (Labonte R, 2010).

The formulation process should be transparent at all levels; the internal level between the various stakeholders and at the external level to the public (Gaveta J, 2002). Thus, documentation of various positions of various stakeholders is recommended through minutes of meetings that need to be published or through any other way (NAO, 2012).

III.B.3 How transparent was the policy formulation process of X Policy as perceived by stakeholders? by public? What made it transparent? What could make it more transparent?

Explanation:

Transparency contributes to having good governance and improves quality of governance of policy making process. Thus, "the policymaking process should be transparent to all stakeholders as well as to the public, since access to information is a public right, it empower citizens, it is a sign of democracy and it increase public trust in government decisions" (NAO, 2012).

III.B.4 How comprehensive is the X Policy? Is the policy document user-friendly& easily accessible? How useful? What is missing?

Explanation:

It is not enough to publish information; the quality of the information will affect the transparency. It have full transparency, the information should be easily accessible to all including the public and should be useful and understandable to all (Otenyo D et al., 2004, Taryn V, 2008).

Policy document should be intended for all; Public, different policy actors and participants, media; can have different documents depending on the intended audience (IHP, 2013).

How information is presented is also an important criterion of transparency (Delphi Expert).

III.B.5 How transparent was the process of priority setting during the development of X Policy? How this process can be improved?

Explanation:

It is a sigh of transparency (Otenyo D et al., 2004).

III.B.6 How transparent is/was the process of resource allocation for implementing the X Policy? Are criteria applied for allocating resources known to all?

Explanation:

It is a sigh of transparency (Relly J et al., 2009).

IV. Information at the policymaking level

Questions and Explanation s/Explanations for the questions:

IV.B.1 How committed is the MoH/Health Authority/National Program leadership to use evidence-based (scientific evidence) and other types of information in policymaking process? What is the evidence for this commitment? Is it documented?

Explanation:

MoH/Health Authority should be committed and should encourage linking evidence to policy (WHO, 2007a, ch:3).

MoH/Health Authority should follow policy driven model where policymakers should demand knowledge to solve specific problems and develop relevant policies (Choi B et al., 2005).

IV.B.2 How can the capacity of staff at the MoH/Health Authority/National Program be improved in terms of to access/use and analysis of research evidence?

Explanation:

MoH/Health Authority should have institutional capacity for generation and use of information in policy (Hanney S et al., 2003).

IV.B.3 Can you describe the relationship between MoH/Health Authority/National Program leadership and researchers? Is their regular interaction?

Explanation:

A good relationship with researchers and academia are important to encourage use of research findings in policy development (Davis P et al., 1996). As research findings are needed to support arguments, justify choice of policies, & inform decisions and it can help in finding solutions that are effectiveness and cost-effectiveness. In addition, research findings are needed to demonstrate best way to implement policies, guide investment decisions in resource constrained settings, improve service delivery and health outcomes (Policy Innovation for Health, Ch:2, Lavis J et al., 2004).

IV.B.4 Do you consider the scientific evidence used in the formulation of X Policy pertinent/adequate? Why? What factors influenced the uptake of evidence-based/research findings into X Policy? What additional evidence would have been necessary?

Explanation:

Several factors might affect the use of evidence-base information in policymaking, and these can be categorized into 4;

1. External Influence: Encouragement & influence of donors & international agencies &Global evidence

2. Context: Consistency with governing party political views, Politics, Economic Resources, Incentives for researchers & policymakers, Opinion of mass media and public, Demand for evidence base, Ways of knowledge transfer/translation, knowledge brokers, Publicly funded research, Government encouragement & commitment for linking evidence to policy , Institutional capacity for research analysis & policy formulation

3. Type of evidence: Technical Content & Quality: reliability, timeliness, specific, comprehensiveness, Practicality, issue complexity, how results communicated: summaries, via media, Feasibility, National significance

4. Stakeholders: Relationship between researchers & policymakers, Acceptability of key stakeholders, Public engagement, Power of pressure groups, Successful advocacy, Partnership, synergy & coordination with academia/research centers.

(Lavis J et al., 2004, Hanny S et al., 2003, Davis P et al., 1996, Choi B et al., 2005, Orem J et al., 2012, Siddiqi S et al., 2012).

All types of Information can be used on regular basis and in emergencies at all levels of policymaking process and should be available to all interested stakeholders.

IV.B.5 How national evidence is generated? What is the role of MoH/Health Authority/National Program in adapting research findings to local context? Give Examples in relation to the X Policy.

Explanation:

It is a governance issue on how evidence is encouraged and generated at the national level and what factors affects its generation (Delphi Expert).

IV.B.6 What other factors (other than evidence-base) contributed to the formulation of X Policy?

Explanation:

The availability of other factors like: financial resources availability, restricting or encouraging governing laws, political situation and commitment, public opinions can influence the formulation process (Jansen M et al., 2010).

Other factors might include catastrophic or crisis situations (natural or man-made) that are common in developing countries (Delphi Expert).

V. Responsiveness at the policymaking level

Questions and Explanation s/Explanations for the questions:

V.B.1 How do you view MoH/Health Authority/National Program institutional capacity to collect/gather public needs/preferences to be incorporated into policymaking process? What Mechanisms can be used to improve policy responsiveness to the population needs?

Explanation:

The MoH/Health Authority should develop mechanisms to improve its responsiveness and this comes of course with a financial cost and a need for human resources (Gaveta J, 2002). Responsiveness is not regularly assessed. Population health needs are usually determined by the health professionals with little involvement of the public (Siddiqi S et al., 2012). Thus, needs assessments and/or public pools might be used to collect public opinions. Public and patient representation is essential in policymaking process.

V.B.2 What are the factors that can positively or negatively influence the responsiveness of MoH/Health Authorities/National Program to the public needs in the policymaking process?

Explanation:

Factors that can influence responsiveness include:

"National Mood", nature of the policy issue, urgency of the and the degree of seriousness/level of priority, costs to be responsive, involvement of changing an old established policy, media coverage, informed public, Informed policymakers, Social movements and pressure, availability of "open window of opportunity", influence of elite, contradictory public opinions, Timing, Government commitment to be responsive to the needs of the population, Inequality in representation (Powell B, 2004, Ura J et al., 2008, Wlezien C et al., 2009, Manza J et al., 2002).

V.B.3 How does the MoH/Health Authority/National Program balance the competing interests/conflicting needs and influence of professionals/elite groups with public opinion (if there is any conflict present between the two opinions)?

Explanation:

It is common that public opinions are manipulated by the elite (interest groups) (Martin D et al., 2002). Thus, the MoH/Health Authority should have access to trusted information on public preferences. Having effective participation is a key in this area. The public/citizens need to be well represented in the policy development process as inequality in representation will lead to inequality in responsiveness (Ura J et al., 2008).

This question is important as it help identify the problem and reflect on action as that can be taken to address potential issues that might arise with “powerful stakeholders” and how the MoH/Health Authority can do better manage and balance their influence against the public needs (Delphi Expert).

V.B.4 Does the MoH/Health Authorities/National Program usually respond to media and/or civil societies reports regarding failure to implement policies? How the response is formulated?

Explanation:

It is important to MoH/Health Authorities to respond to media and NGO reports when needed as part of being responsive and this should be done on timely manner (Delphi Expert).

V.B.5 How responsive is the X Policy to the population needs in general? And to the vulnerable population needs in particular? Is the policy patient-centered? Please explain

Explanation:

MoH/Health authorities should pay attention to developed policies to address legitimate expectations of the people (including the vulnerable population) as this is one of the outcomes of the governance function of the health systems. "Responsiveness of health system can be improved much faster than health without large investments" (Darby C. et al., 2000).

Having responsive health polices can improve people well-being irrespective of improvements to their health just by their interaction with the health system. Ensuring that people are treated in ways that correspond to their needs can lead to healthier lives (Darby C et al., Gostin L et al., 2003).

V.B.6 How do you perceive the timeliness as well as the promptness of developing the X Policy in response to population legitimate needs?

Explanation:

Prompt attention to the needs of the population in a timely manner is another element of responsiveness (Gostin L et al., 2003).

Chapter V: Limitations

The HP-GGT is not a perfect tool. Like with any other tool it has some limitations.

The findings of the assessment will depend greatly on the existence of relevant documents to be reviewed as the culture of documentations in some countries might be poor. Also identifying the relevant KIs to be interviewed is critical. Identifying relevant KIs is a key success for the assessment; as the results obtained will depend on the number of KIs who will accept to be interviewed, KIs' level of knowledge about the policy process being evaluated, and their openness in responding to the questions. It is crucial to have a mix of KIs to obtain multi-perspective reflection on the policy development process. Thus, KIs should include government officials, representatives of private sector, NGOs, academia, professional societies and others with relevant involvement in the policy development.

Translating the tool into other languages (especially Arabic) might be a problem since the translation might create some inaccuracies.

The tool is long and it needs a minimum of 2 hours to conduct both sections (around one hour for each). This might result in low rate of acceptance by KIs when they know about the time needed to complete the assessment given their tight schedule, that is why it is suggested to conduct two separate interviews with the same KIs given they will accept this option. Some KIs will accept to cover only one section of the tool. While others will not mind dedicating this time as long as it is scheduled a head of time.

Glossary:

- **Conflict of Interest:** means that the participant or his/her partner including a spouse or other person with whom s/he has a similar close personal relationship) has a financial or other interest that could unduly influence the participant's position with respect to the subject matter being considered (WHO, 2009).
- **Delphi Experts:** are "Governance" experts who participated in reviewing the tool and giving their feedback via Delphi consultation process that took place via email over three rounds of review.
- **Easily Accessible:** Obtained effortlessly with no delay or any bureaucratic obstacle as needed and/or upon request (WHO, 2009).
- **Ethical accountability**: mostly related to health professionals & abiding by code of conduct (Emanuel E, 1996, Brinkerhoff D., 2004).
- **Financial accountability:** concerns tracking and reporting on allocation, disbursement and utilization of financial resources using tools of auditing, budgeting and accounting. (Emanuel E, 1996, Brinkerhoff D., 2004).
- **Formal Mechanism/Body:** If it defined by a law or other mechanism then it is formal.
- **Informal Mechanism/Body:** Not defined by a law or something formal, asking opinion of a stakeholder via email is considered informal mechanism.
- **Legal accountability:** related to violation of laws (Emanuel E, 1996, Brinkerhoff D., 2004).
- **Patient-centered:** is when individuals, families and communities are served by and are able to participate in trusted health systems that respond to their needs in humane and holistic ways. The health system is designed around stakeholder needs and enables individuals, families and communities to collaborate with health practitioners and health care organizations in the public, private and not-for-profit health and related sectors in driving improvements in the quality and responsiveness of health care (WHO, 2007c).
- **Performance accountability:** refers to demonstrating and accounting for performance in light of agreed-upon performance targets (Emanuel E, 1996, Brinkerhoff D., 2004).
- **Publicly available:** to be found openly, widely and with no restrictions and to be found in usually in more than one media (Soft copy: website, hard copy: at governmental office, or documentation center or in national gazette (WHO, 2009).
- **Whistle blowing:** is when a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organization that is either

private or public. The information of alleged wrongdoing can be classified in many ways: violation of company policy/rules, law, regulation, or threat to public interest/national security, as well as fraud, and corruption. Those who become whistleblowers can choose to bring information or allegations to surface either internally or externally. Internally, a whistleblower can bring his/her accusations to the attention of other people within the accused organization. Externally, a whistleblower can bring allegations to light by contacting a third party outside of an accused organization. Whistleblowers can reach out to the media, government, law enforcement, or those who are concerned but also face stiff reprisal and retaliation from those who are accused or alleged of wrongdoing (Wikipedia).

- **Watchdogs' organizations**: are usually non-profit groups that view their role as critically monitoring the activities of governments, industry, or other **organizations** and alerting the public when they detect actions that go against the public interest (soursewatch.org).

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Diagram 1: Framework for the HP-GGT

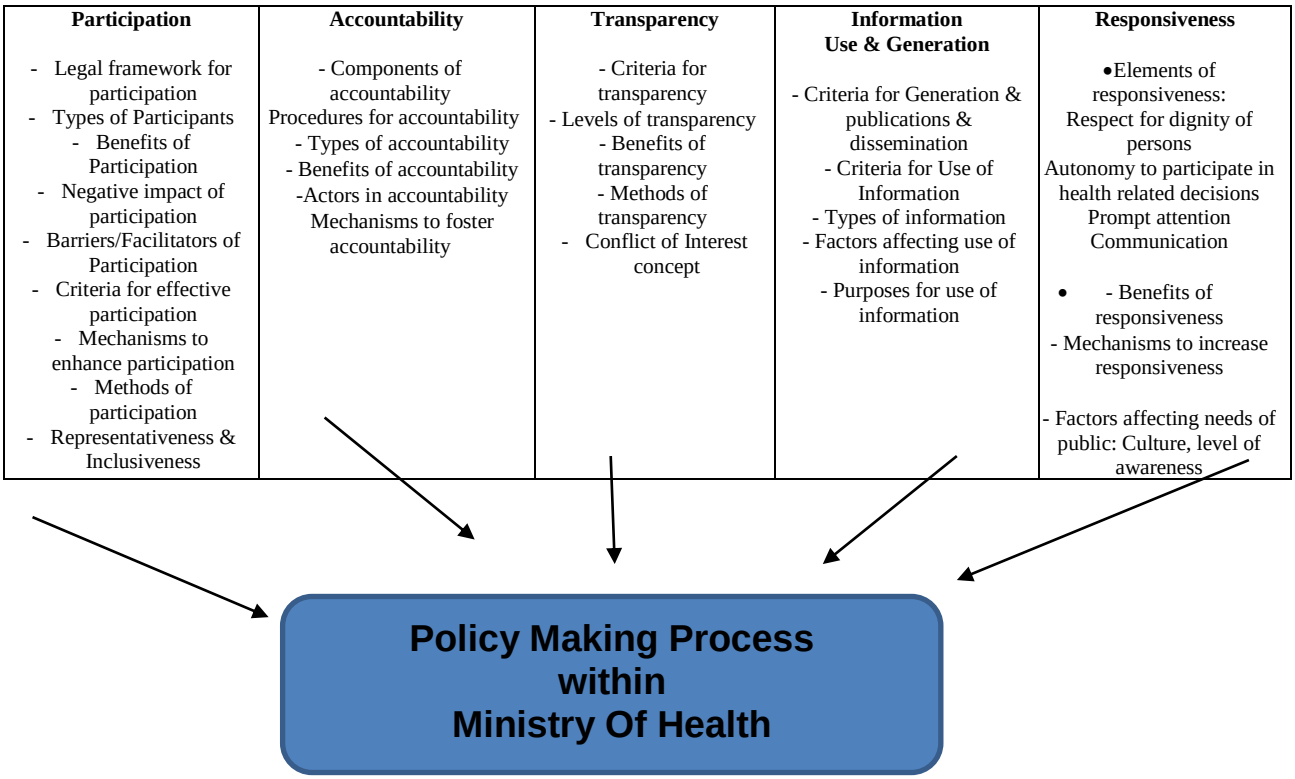
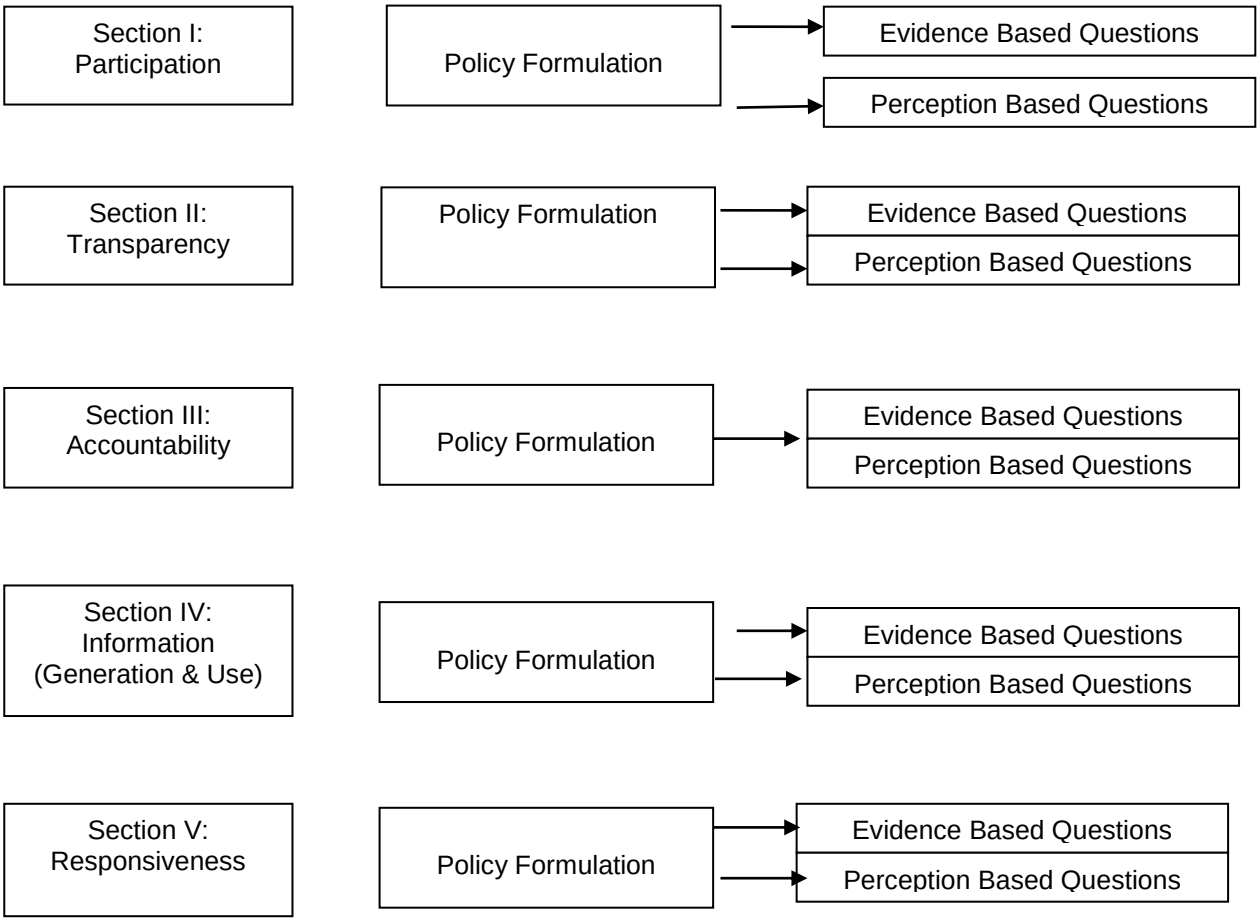


Diagram 2: Structure of the HP-GGT



Evidence-Based Questions to collect relevant data from Desk Review & KI Interviews

Perception-Based questions to collected relevant data from KIs Interviews

Annexes-Manual

Annex 1-Manual:

A. Letter/Email addressed to KIs

Request to participate in the Assessment of Governance at the Health Policymaking Level-XXXX Health Strategy using a Guidance Tool

Dear Dr. ….

Greetings. Hope this email finds you well.

You are being invited to take part in conduction of Governance Guidance Tool. The conduction of the tool will be done in relation to the newly developed National XXXX Health Strategy.

I am sure that you have many questions before you consider saying YES to this request, and I hope that I will be able to answer most of your questions by the below:

What's the project? Assessment of Governance at the health policymaking level of XXX Health Strategy

What is the project aims? The tool will enable health ministries/health authorities or other international organizations and others to examine the extent to which key governance principles are applied in health policymaking. The governance tool is organized around five key governance principles: participation, transparency, accountability, use of information & responsiveness.

What is the project output? The governance guidance tool is a practical, robust and adaptable for stakeholders to use in diverse developing country health contexts. The final report of the assessment should document successes, identify weaknesses, challenges, and recommend ways by which health governance can be strengthened at the policymaking level.

Who is leading this project? My name is……., I am the principle investigator. I work in ……

Why me and what do you want from me as a participant? Since you were actively involved in the National XXXX Health Strategy development, thus you are considered as a Key Informant and your informed opinion about the process of development of the strategy is essential for this assessment.
Thus, we would like you to take part in face-to-face interviews (one or two) with principle investigator.
Your contribution is central to the assessment process.

What is involved? The tool has **Two Sections**; one with close ended questions and the other contains open ended questions. Thus, you will be asked various questions in relation to the National XXXX Health Strategy in terms of formulation and implementation plans.

How much time will it take & when? If you accept to participate in the piloting, you are kindly asked to assign TWO separate meeting times (if possible) at your convenience to conduct face-to-face interviews to cover the two sections of the tool. Each interview might take around 50 minutes to be completed. You may wish to have one interview to conduct both sections of the tool. Interviews will be conducted in a place convenient for you.

I would like more information, where can I find it? For more information, kindly see the Information Sheet attached. Also you can contact me via: ……..

When do you need to know whether I could be involved? If you agree to participate, kindly return by email by…… with your approval & consent to be part of the assessment (or you can sign during our meeting before we start the interview). Informed consent attached.

Hope to hear from you soon
Warm Regards

B. Participant Information Sheet

Title of the Study: Assessment of Governance at the Health Policymaking Level-XXXX Health Strategy using a Guidance Tool

Investigators:

- Principle Investigator (PI): XXXXX

e-mail:

Telephone:

Introduction:

WHO defines Governance as "ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, provision of appropriate regulations and incentives, attention to system-design, and accountability". Governance is considered one of the six building blocks of any health systems. Yet, governance is the least understood aspect of these, most difficult to measure and its implementation the least evaluated. There are 10 core principles that are relevant to the health system governance. These are: strategic vision, participation & consensus orientation, rule of law, transparency, responsiveness, equity and inclusiveness, effectiveness and efficiency, accountability, intelligence & information and ethics.

Purpose & Value of the Study:

The aim of this research is to identify/examine if characteristics of selected governance principles (participation, transparency, accountability, use of information & responsiveness) exist/practiced at the policymaking level. The selected governance principles will be assessed at policymaking process due to importance of policymaking in shaping health of population, and as major practice of Ministries of Health (MOHs)/Health Authorities in governance process. The selected principles will be assessed at the main stage of health policy process; formulation and implementation plans, as this is the most important for evaluating governance quality. Since health system governance is considered to be a function of MOHs specifically where they are responsible for promoting, and maintaining well-being of population through its role in regulatory and policymaking. Thus, unit of analysis for this study will be MOHs. Undertaking such analysis will assist in assessing ability of MOHs to formulate and implement sound policies and regulations.

The assessment will be flexible enough to be used to analyse process of policymaking of any type of health policy and to be adapted to country context. It can be used as an entry point to be used by policymakers to assist MOHs in countries to better govern their health systems.

Description of the Process of Participation in this Study:

For Key Informants (KIs) taking Part in the Assessment

You are selected as a Key Informant as you were identified as knowledgeable about, directly involved, and interested in the **National XXXX Health Strategy** that was recently developed.

If you agree to participate, kindly set TWO separate meeting times (if possible) and a meeting place that is convenient to you to conduct face-to-face interviews with you where you will be asked various questions in relation to the National XXXX Health Strategy in terms of formulation and implementation plans.

The reason for having two interviews with you; is that the tool has two sections. One section contains close ended questions and might take around 50 minutes to complete and the other section contains open ended questions (for better understanding of the process that was followed during the policy formulation) and it might take another 50 minutes to complete.

If you wish, the two sections can be covered within the same interview.

We would like to tape-record the interview if you agree and you are free to refuse to answer any question and it is your right to stop at any time.

Confidentiality will be respected in all stages of study, your name and your responses will be anonymous as all will be coded and you will be asked to sign a written informed consent.

Raw data will be available only to the PI and all related documents of the study will be stored under lock for at least 3 years.

You may be contacted by the PI after the interviews for any follow up or clarifications.

If you have any questions, clarifications about this study or about the objectives of this research before the interview or during, please contact the PI for this research project.

There is no direct benefit to you for participating in this study. No risks of any kind will be inflicted on the participants.

PI
XXXXX

C. Informed Consent

Title of the Study: Assessment of Governance at the Health Policymaking Level-XXXX Health Strategy using a Guidance Tool

- Principle Investigator (PI): XXXX

e-mail: Telephone:

Purpose of the Study:

The aim of this research is to conduct an assessment to identify/examine if characteristics of selected governance principles (participation, transparency, accountability, use of information & responsiveness) exist/practiced at the policymaking level.

The developed tool will assess abilities of Ministries of Health/Health Authorities (in developing countries) in applying principles of good governance at the health policymaking level and it can be used as an entry point to be used by policymakers to assist MOHs/Health Authorities in countries to better govern their health systems.

Consent:

I, ..., agree to take part as a Key Informant in the assessment using the guidance tool that is part of this study. I agree to participate in ONE / TWO (circle your choice) face-to-face interview (s) and answer various questions and I approve that I might be contacted again by the Principle Investigator as a follow up on the study if needed.

I declare, that I have read the participant information sheet that was provided to me about the study and what will be my role in it, and all my questions and concerns were answered by the PI.

I understand that it is my right to ask any question during the interview and refuse to answer any question and stop the interview at any time. I agree that the interview may be recorded using a digital recorder for an accurate record of the interview and that notes may also be taken.

I understand that my words may be quoted in published work, but that I will not be identified, and that all identifying information will be removed before publication.

I was informed that the confidentiality will be respected in all stages of study, and my name and responses will be anonymous as all will be coded and personal as well as raw data will be available only to the PI and all related documents of the study will be stored under lock for at least 3 years.

Name of Participant: Date: Signature:

Annex 2-Manual: Sample of Excel Sheet for Data Entry
Section A: I Participation

	1	2	3	4	5	6	7
Type of KI*	P	G	I	INGO	A	NGO	SS
I.A.1							
Policy formulation							
Policy implementation							
Other							
Not Specified							
If No, is there still a commitment							
I.A.2							
A national committee							
Advisory Board							
Working Group (s)							
Other							
Formally							
Informally							
Written Mandate/scope							
Roles & Responsibilities							
Qualifications							
Timetable							
I.A.3							
State Actors: Other than MOH							
Health Service providers							
Parliamentary members							
Beneficiaries &/or Public							
Civil Society/NGOs							
International organizations							
Funders/Financiers							
Academic Institutions/Researchers							
Private Sector							
Most Vulnerable populations							
Media							
Others							
I.A.4							
Appointed							
Elected							
Self-selected							

Voluntary							
Mandatory							
Representing Themselves							
Representing their organizations							
I.A.5							
I.A.6							
Cost of meetings							
Cost for administrative work							
Incentives for participants							
Transportation, lodging and/or meals							
I.A.7							
Publicly Available							
I.A.8							
Majority Vote							
Consensus							
Dissenting Opinions							
Other Procedures							
Not Specified							
Is it documented?							
I.A.9							
Defines by Law							
I.A.10							
I.A.11							
Opinion Polls/Surveys							
Focus groups							
Public Hearings/Public Comments							
Online platforms							
Voting							
Hotline							
Inter-governmental conferences							
Policy dialogues							

*P: Private Sector
G: Government
NGO: Nongovernmental organization
INGO: International nongovernmental organization
A: Academia
SS: Scientific Society
I: International Agency

Annex 9. Sample Comparison on How Siddiq et al. are Proposing to Assess Participation vs. How HP-GGT Is Proposing to Be Assessed

Siddiqi et al., 2009 Assessment of Participation	HP-GGT Assessment of Participation
- Are the private sector, civil society, line departments and other stakeholders consulted in decision making? - How are decisions related to health finalized: cabinet, parliament, head of government or state? - How are the inputs solicited from stakeholders for health policy? - How does government reconcile the different objectives of various stakeholders in health decision-making? - Are other state ministries involved in by the MOH in policies and programs to tackle health determinants?	- Is there a Legal basis/requirement (Law/Regulation/Policy) to include various stakeholders in health policymaking process? **If Yes,** Specify what is it? & in what phase of the policymaking process is it specified to consult with stakeholders **If No**, is there still a commitment from the MoH/Health Authority/National Program to ensure some degree of stakeholders participation in formulation & implementation of national health policies? - Was there a body or mechanism(s) used to involve stakeholders in policymaking process that was concerned with the development of the **X Policy**? **If Yes,** what body or mechanism (s) was used to involve stakeholders in the policymaking process that was concerned with the **X Policy**? A national committee An advisory Board Working Group (s) Other, Specify: - How was this body /mechanism (mentioned above) formulated? Formally (in written format), Specify How & By Whom: Informally, Specify How: If it was Formally formulated, - Was there a written scope/mandate for stakeholders' involvement in the formulation of the **X Policy**? What is the scope/mandate for the stakeholders? Were the roles and the responsibilities of participants for the various stakeholders specified? Were the qualifications of participants for the various stakeholders specified? Was there a timetable for the work to be carried out? - Were the following stakeholders represented in the FORMULATION that was concerned with **X Policy?** State Actors (Government, other than MoH, National, Local): Specify: Health Service providers (Professional Association/Unions/Orders & Health Service Organizations/Hospital boards) Specify: Parliamentary members Beneficiaries (patients associations) &/or Public: Specify: Civil Society: Specify: Development Partners/International organizations: Specify: Funders/Donors: Specify Academic Institutions/Researchers: Specify: Private Sector (medical, pharmaceutical industry, insurance companies): Specify: Most Vulnerable or Key affected populations: Specify: Media Others: Specify: Were representatives from local/regions within X Country represented? How? - For each category of stakeholders identified above, how were the participants involved in formulation of **X Policy** selected? Appointed, Nominated was there a set criteria for the selection? Elected, by whom? Self-selected Others: Was their participation: Voluntary

	Mandatory - Are participants: Representing Themselves: Specify: Representing their organizations: Specify: Other, Specify: - Is there a gender balance /consideration (Male vs. Female) among the stakeholders participating in the formulation of the **X Policy?** - Are there dedicated resources made available by the MoH/Health Authority to enable and facilitate participation during the policy development process of **X Policy**? **If Yes,** what type of resources is made available? Cost of meetings (venues, coffee breaks, etc) Cost of Administrative work (print outs, etc) Incentives for participants (Fee or Honoraria): Specify: Transportation, lodging and/or meals (Direct Payment or Reimbursement): Specify: Other, Specify: - Is there documentation (Minutes of meetings) on the recommendations submitted for final decisions in relation to the formulation of the **X Policy**? - Are the minutes published/made available to the public? - How final decisions were taken by participants: Majority Vote Consensus Dissenting Opinions Other Procedures Not Specified Is there documentation of this? - Are the roles and responsibilities of the various stakeholders in the implementation process specified in the formulation document of the **X Policy**? **If NO**, are they defined by law or by any other formal means? - Is there a participatory body to oversee the implementation of the **X Policy**? **If Yes,** What is its composition? - Are other mechanism/strategies used by MOH/Health Authority/National Program to ENCOURAGE participation (express opinions/preference and encourage feedback) of different stakeholders in priority setting and in policymaking process of **X Policy**? **If YES,** which mechanisms are used *(* Opinion Polls/Surveys Focus groups Public Hearings/Public Comments/Citizens Juries Online platforms Voting Hotline Inter-governmental conferences Policy dialogues Others, specify: -How do you view the role of MoH/Health Authorities/National Program in encouraging stakeholders' participation in policy formulation and implementation in general? & in the **X Policy** development in specific? Does the MoH/Health Authority/National Program has the institutional capacity and needed resources to facilitate the participation process? In terms of leadership? Planning? Needed information? Institutional arrangements? Database of key stakeholders? - To what extent was the formulation process of the **X Policy** inclusive of the key stakeholders? Were they "Effectively "consulted**?** Were all relevant voices taken into account? Which

	stakeholders were missing? - What type of process was applied for the selection/identification of participants in the **X Policy** formulation? Do You consider that it was a fair/effective process to ensure a qualified group? A representative group? Why? - Who were the powerful stakeholders in the decision making/formulation of the **X Policy**? Was their influence hindering or facilitating the formulation process of **X Policy**? What their influence led to? - What are the barriers and/or facilitators to the participatory process? For MoH/Health Authorities/National program? For stakeholders? - What are the mechanisms used to enable stakeholder participation in policymaking process? Do they include mechanisms to give voice to the traditionally voiceless groups (homeless, migrants/refugees, unemployed, minorities, disabled, elderly, etc?? How do you view the effectiveness of these mechanisms?